Contract

Between

Insurance and Care NSW (ABN 16 759 382 489) in its own right and acting for the **Workers Compensation Nominal Insurer (ABN 83 564 379 108)**

And

Employers Mutual NSW Limited (ABN 52 003 201 885); and

Employers Mutual Management Pty Limited (ABN 11 001 735 191)

for the provision of Nominal Insurer Workers Compensation Claims and Injury Management Services

About this Contract

1 Strategic objectives

The Nominal Insurer insures private employers in NSW for workers compensation liabilities, unless the employer has been approved by SIRA to act as a self-insurer. icare is a NSW government agency that acts for the Nominal Insurer.

The Nominal Insurer is authorised to enter into agency arrangements for the appointment of persons to act as a Scheme Agent in connection with the exercise of any functions of the Nominal Insurer. This Contract sets out the basis on which icare, acting for the Nominal Insurer, has appointed the Claims Service Provider as a Scheme Agent.

In 2017, icare decided to appoint a single Scheme Agent to manage all new claims received, and subsequently decided to appoint additional Scheme Agents known as “authorised providers”. As part of a procurement process undertaken during 2022, icare decided to expand the number of Scheme Agents, including a number of agents with specialised capability to manage more complex claims that typically have a longer duration and greater support costs. The remuneration model for this Contract seeks to incentivise conduct by each Scheme Agent that will:

- increase the number, experience and capability of case managers compared to the position before this Contract commenced, as this should lead to superior service and outcomes for Workers and Employers;
- promote recovery at work for injured Workers, by valuing genuine return to employment; and
- encourage innovation to improve scheme performance and/or customer experience.

This Contract has been drafted so that, as far practicable, it is consistent for all Scheme Agents, with variations from standard positions documented in Special Conditions, the Transition-In Plan and certain schedules. This is for ease of administration by icare in its role as a manager of outsourced providers.

About this Contract

Transparency of performance as between Scheme Agents is critical to the new panel. SIRA's Workers Compensation Performance Framework analyses the performance of the different types of insurers involved in workers compensation in NSW, including the Nominal Insurer. As part of this Contract, Scheme Agents must provide data that icare will use to compile information about all scheme agents (including in relation to their performance and capabilities). This information may be made available to all Scheme Agents and relevant stakeholders, including to Employers so they can make informed decisions when exercising choice as to which Claims Service Provider should manage Claims under their policies, and to SIRA so that the regulator has greater insight into the performance of the Nominal Insurer.

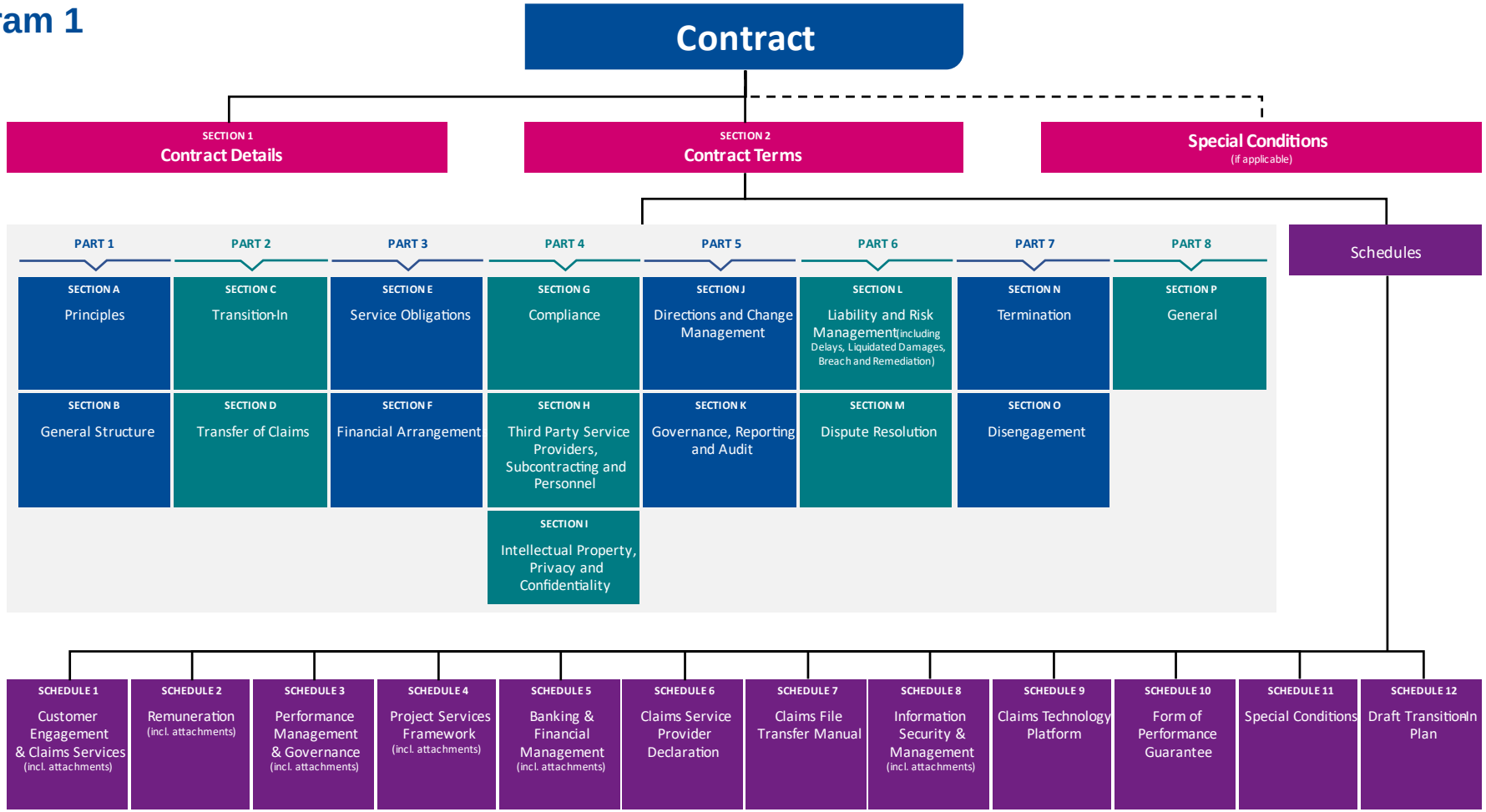
This Contract is intended to form a long term framework under which icare and each Scheme Agent can work together. The parties acknowledge that changes will occur from time to time during the term of the Contract, details of which cannot be anticipated. In responding to such changes, the parties have agreed to act in good faith and consistently with a defined set of Workers Compensation Scheme Principles.

2 How to use this Contract

- The structure of this Contract is shown in Diagram 1 overleaf.
- Section 2, which contains the Contract Terms, is divided into 8 Parts. These Parts mirror the contractual relationship stages from entry to exit, as shown in Diagram 2 overleaf.
- A table of contents is located on page 12.
- The Dictionary is located at clause 64 of Section 2.

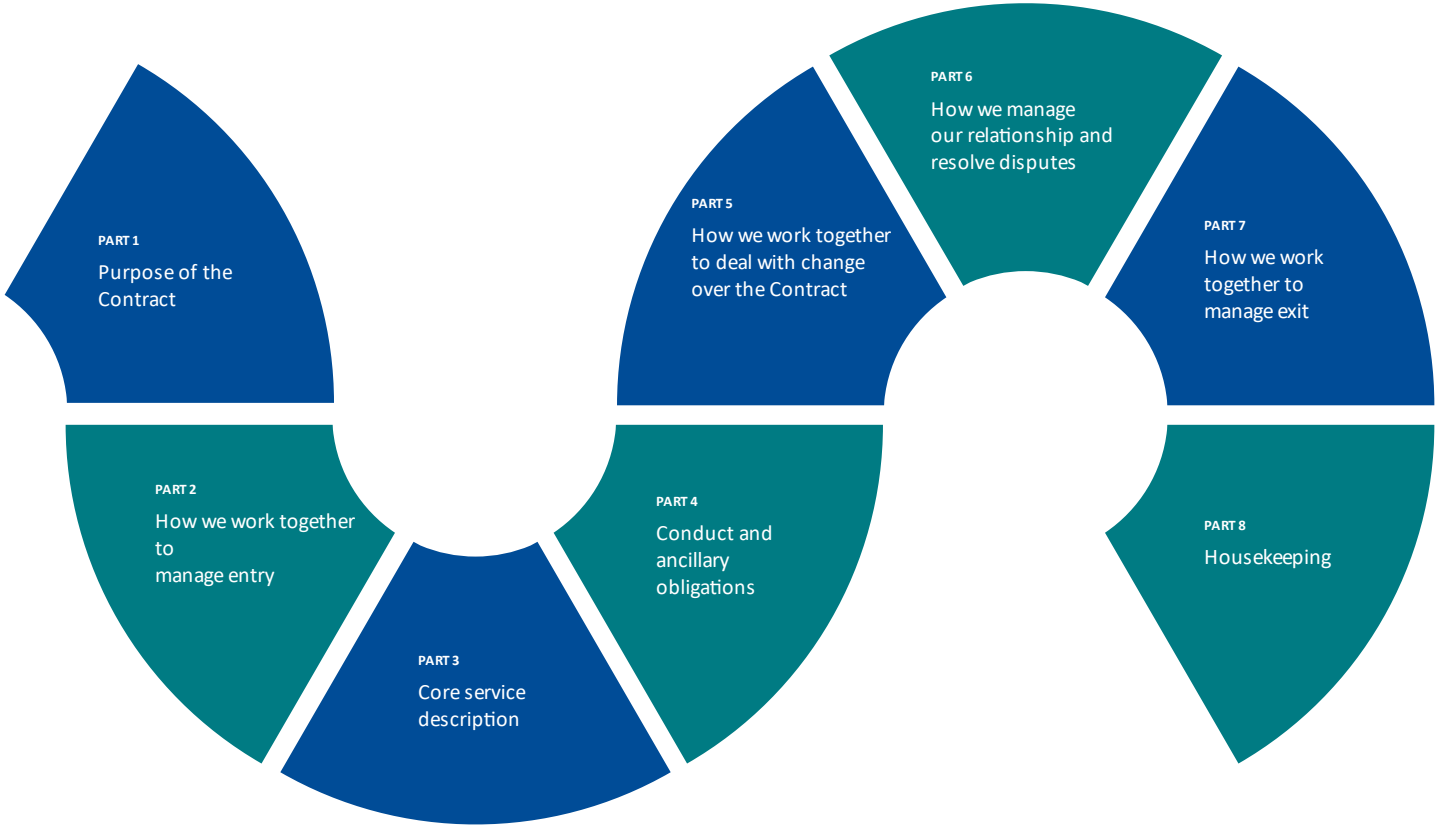
About this Contract

Diagram 1



About this Contract

Diagram 2



Section 1 Contract Details

1.	**Parties**	**Insurance and Care NSW (ABN 16 759 382 489)** in its own right and acting for the **Workers Compensation Nominal Insurer** (**ABN 83 564 379 108**) (**icare**) of 321 Kent Street, Sydney NSW 2000; and **Employers Mutual NSW Limited (ABN 52 003 201 885)** (**Claims Service Provider**) of Level 3, 345 George St, Sydney NSW, 2000; and **Employers Mutual Management Pty Limited** (ABN 11 001 735 191) (**Asset Owner**) of Level 3, 345 George St, Sydney NSW, 2000.
2.	**Recitals**	A The Workers Compensation Nominal Insurer (Nominal Insurer) was established by the 1987 Act. B Section 154C of the 1987 Act provides that icare acts for the Nominal Insurer. C Section 154G of the 1987 Act permits icare to enter into arrangements with persons to act as Scheme Agents for the Nominal Insurer. The 1987 Act allows Scheme Agents to exercise any functions of the Nominal Insurer, subject always to the direction and control of the Nominal Insurer under any agency arrangement and any relevant legislation. D icare has agreed to appoint the Claims Service Provider as a Scheme Agent to exercise certain functions of the Nominal Insurer, subject to this Contract. E The Claims Service Provider has represented and represents that it has the skills, qualifications and experience necessary to perform and manage the Services in an efficient and cost-effective manner, with a high degree of quality and responsiveness. icare has agreed to enter into the Contract in reliance on the Claims Service Provider's representations. F The Claims Service Provider agrees to act under this Contract in a way that facilitates the achievement of the Workers Compensation Scheme Principles and will collaborate with icare throughout the Term to

		enable Claims to be effectively managed so as to achieve optimal health and employment outcomes. G The Claims Service Provider agrees to provide the Services in accordance with the terms of this Contract. H The Asset Owner is a party to this Contract for the purposes of Special Condition 4 of Schedule 11 ("Special Conditions") only.
3.	**Contract number**	
4.	**Commencement Date and Services Commencement Date** (Dictionary)	**Commencement Date** 1 January 2023 **Services Commencement Date** 1 January 2023
5.	**Contract Term** (clause 4 Contract Terms)	**Initial Contract Term:** five years from the Commencement Date **Extension Period 1:** three years **Extension Period 2:** two years
6.	**CSP Category appointment as at the Commencement Date** (Dictionary and clause 6.5 Contract Terms)	**CSP Category appointment** ☐ generalist; ☐ specialist; or ☒ generalist with specialist capabilities.
7.	**Relevant Fund**	Workers Compensation Insurance Fund
8.	**Approved Locations** (Dictionary and clause 10 Contract Terms)	None at the Commencement Date. See clause 10(b) in relation to Pre-Existing Locations.
9.	**Service Company** (Dictionary)	Employers Mutual Management Pty Limited (ABN 11 001 735 191)

<table>
<tr>
<td>10.</td>
<td>icare Authorised Representative and Partnering and Performance Manager
(Dictionary, clause 43 and 44 Contract Terms)</td>
<td>
icare Authorised Representative
<table>
<tr><td>Name</td><td>Mary Maini</td></tr>
<tr><td>Title</td><td>Group Executive Workers Compensation</td></tr>
<tr><td>Address</td><td>321 Kent Street, Sydney NSW 2000</td></tr>
<tr><td>Telephone</td><td>(02) 7922 1383</td></tr>
<tr><td>Email</td><td>icareAuthorisedRep@icare.nsw.gov.au</td></tr>
</table>
icare Partnering and Performance Manager
<table>
<tr><td>Name</td><td>Tim Dill</td></tr>
<tr><td>Title</td><td>Head of Commercial Performance</td></tr>
<tr><td>Address</td><td>321 Kent Street, Sydney NSW 2000</td></tr>
<tr><td>Telephone</td><td>04[redacted]</td></tr>
<tr><td>Email</td><td>EMLNI@icare.nsw.gov.au</td></tr>
</table>
</td>
</tr>
<tr>
<td>11.</td>
<td>Claims Service Provider Authorised Representative and Partnering and Performance Manager
(Dictionary and clause 43 and 44 Contract Terms)</td>
<td>
Claims Service Provider Authorised Representative
<table>
<tr><td>Name</td><td>Matthew Vickers</td></tr>
<tr><td>Title</td><td>General Manager – Workers Insurance</td></tr>
<tr><td>Address</td><td>3/345 George Street Sydney NSW 2000</td></tr>
<tr><td>Telephone</td><td>02 8251 9156</td></tr>
<tr><td>Email</td><td>matthew.vickers@eml.com.au</td></tr>
</table>
Claims Service Provider Partnering and Performance Manager
Both of the following are appointed but each can act unilaterally:
<table>
<tr><td>Name</td><td>Salvatore Failla</td></tr>
<tr><td>Title</td><td>Contract Manager</td></tr>
<tr><td>Address</td><td>3/345 George Street Sydney NSW 2000</td></tr>
<tr><td>Telephone</td><td>02 8251 9390</td></tr>
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<tr><td></td><td></td><td>
<table>
<tr><td>Email</td><td>s.failla@eml.com.au</td></tr>
</table>
<table>
<tr><td>Name</td><td>Adam Keogh</td></tr>
<tr><td>Title</td><td>Group General Manager - RTWSS</td></tr>
<tr><td>Address</td><td>3/345 George Street Sydney NSW 2000</td></tr>
<tr><td>Telephone</td><td>02 8251 9388</td></tr>
<tr><td>Email</td><td>a.keogh@eml.com.au</td></tr>
</table>
</td></tr>
<tr><td>12.</td><td>Addresses for notices
(clause 61 Contract Terms)</td><td>icare
Property address: Level 15, 321 Kent Street, Sydney NSW 2000
Email: NIContracts@icare.nsw.gov.au
Attention: Group Executive, Workers Compensation

Claims Service Provider
Property address: Level 3, 345 George Street, Sydney NSW 2000
Email address: NICorrespondence@eml.com.au
Attention: General Manager – Workers Insurance</td></tr>
<tr><td>13.</td><td>Performance Guarantee
(clause 26 Contract Terms)</td><td>Clause 26 of the Contract Terms applies to this Contract</td></tr>
<tr><td>14.</td><td>Financial Security
(clause 27 Contract Terms)</td><td>Clause 27 of the Contract Terms does not apply to this Contract</td></tr>
<tr><td>15.</td><td>Compliance in procurement
(clause 25 Contract Terms)</td><td>Small and Medium Enterprises and Regional Procurement Policy
Clause 25.1 (Small and Medium Enterprises and Regional Procurement Policy) applies to this Contract.

Small Business Shorter Payment Times Policy
Clause 25.2 (Small Business Shorter Payment Terms Policy) applies to this Contract.

Aboriginal Participation Requirements
Clause 25.4 (Aboriginal Participation) applies to this Contract.</td></tr>
</table>

16.	**Commercial in confidence terms** (clause 35.1 Contract Terms)	Any provisions of this Contract that disclose: (a) a party's financing arrangements; (b) a party's cost structure or profit margins; (c) a party's full base case financial model; (d) a party's intellectual property, or intellectual property in which that party has an interest; or (e) any matter the disclosure of which would place that party at a commercial disadvantage in relation to its competitors, whether at present or in the future, and including Schedule 2 (Remuneration) and its Attachments, Attachment 3.01 (Operational Measures), Schedule 10 (Form of Performance Guarantee), Schedule 11 (Special Conditions), and any other provision, Schedule or Attachment that relates to remuneration, financial security, information security or control-related activities or functions.
17.	**Special Conditions** (Dictionary)	The Special Conditions are as set out in Schedule 11 ("Special Conditions").

Section 2 Contract Terms

TABLE OF CONTENTS

Part 1 Purpose of the Contract

Simplified outline of this Part:

This Part 1 contains:

- Section A – Workers Compensation Scheme Principles; and
- Section B – General Structure.

Section A sets out the Workers Compensation Scheme Principles – the Claims Service Provider must act consistently with the principles and facilitate their achievement. Section A also establishes the Claims Service Provider's appointment as icare's agent.

Section B sets out the structure of the Contract, and the term of the Contract - an initial 5 year term with two extension periods (a period of three years and two years respectively) that icare can exercise.

SECTION A - Principles

1. Workers Compensation Scheme Principles

1.1 Achievement of Workers Compensation Scheme Principles

(a) The Claims Service Provider agrees that it must perform its obligations under this Contract, and act in all respects under this Contract and in connection with the Scheme, in a way which is consistent with, and facilitates the achievement of, the Workers Compensation Scheme Principles.

(b) The Claims Service Provider acknowledges and agrees that icare and the Scheme are dependent on the Claims Service Provider fulfilling, to the best of its ability, the Workers Compensation Scheme Principles.

1.2 Definition of Workers Compensation Scheme Principles

The Workers Compensation Scheme Principles support the "workplace injury management and workers compensation system" objectives defined in section 3 of the 1998 Act. The "**Workers Compensation Scheme Principles**" are to:

(a) promote recovery at work and the health benefits of returning to work, and to manage Claims effectively to achieve optimal health and employment outcomes;

(b) provide a proactive, tailored and intensive Claims Management approach that effectively identifies and mitigates Return to Work barriers and risks and supports Workers to recover and Return to Work;

(c) treat Workers and Employers fairly and reduce complexity;

(d) be accountable, consultative and transparent in all interactions under the Scheme, including with Workers, Employers and Other Claims Service Providers; and

(e) foster innovation to improve efficiency, improve the Worker and Employer experience, and to ensure financial sustainability of the Relevant Fund.

2. Agency – relationship

2.1 Scope of agency

icare appoints the Claims Service Provider to provide the Services and to act as a Scheme Agent of icare in accordance with this Contract for the Term.

SECTION B - General structure

3. General

3.1 Contract parts

This Contract consists of:

(a) the Special Conditions (as set out in Schedule 11 (“Special Conditions”));

(b) these Contract Terms (being clauses 1 to 65 inclusive, at Section 2 of this Contract);

(c) the Contract Details (at Section 1 of this Contract);

(d) the Schedules (other than Schedule 11 (“Special Conditions”));

(e) Attachments and appendices;

(f) any Statement of Work entered into under the Contract; and

(g) any document expressly incorporated into this Contract.

3.2 Inconsistency

If there is any inconsistency between the parts referred to in clause 3.1, then the part higher in the list prevails to the extent of such inconsistency.

3.3 Inconsistency with legislation

If there is any inconsistency between this Contract (in accordance with clause 3) and any right or obligation in the WH&S and Workers Compensation Legislation, then the WH&S and Workers Compensation Legislation will prevail over this Contract to the extent of such inconsistency.

4. Term

4.1 Term of Contract

This Contract commences on the Commencement Date and continues for the duration of the Initial Contract Term, unless extended under clause 4.3(a) or terminated earlier.

4.2 Fees to apply during Initial Contract Term

The Fees that apply during the Initial Contract Term are set out in Schedule 2 ("Remuneration"). The parties may agree an adjustment to the Fees to apply during the last two years of the Initial Contract Term, as set out in Schedule 2 ("Remuneration").

4.3 Extension of the Contract

(a) icare may extend the term of this Contract beyond the Initial Contract Term for:

(i) Extension Period 1; and

(ii) Extension Period 2,

by giving the Claims Service Provider at least three months' notice prior to the end of the Initial Contract Term and Extension Period 1 respectively, in which case the Claims Service Provider will continue to perform the Services on the same terms and conditions as set out in this Contract for the applicable Extension Period except:

(iii) to the extent the parties agree to amend those terms and conditions under clause 4.3(b) or otherwise; and

(iv) provided that icare may in its notice update the Workers Compensation Scheme Principles that will apply to the Contract during the applicable Extension Period to reflect then current Law and Regulatory Guidance.

(b) A party may request amendments to the provisions of this Contract, such amendments to be effective during the applicable Extension Period, by providing the other party with a notice detailing the requested amendments at least 9 months prior to the end of the Initial Contract Term or Extension Period 1 (as applicable). If a party gives a notice under this clause 4.3(b), the parties will meet to discuss those requested amendments but no amendments will be effective unless agreed in writing by the parties.

(c) Nothing in clause 4.3(b) limits:

(i) icare's other rights under the Contract to amend a provision or other constituent part of this Contract; or

(ii) the ability of the parties to discuss and agree amendments to this Contract at any other time during the Term.

Part 2 How we work together to manage entry

Simplified outline of this Part:

This Part 2 contains:

- Section C – Transition-In; and
- Section D – Transfer of Claims.

Section C sets out the parties' obligations in respect of planning for Transition-In, and the subsequent implementation and acceptance of Transition-In.

Section D sets out the framework for Transfer of Claims, including the circumstances in which icare may direct the Claims Service Provider to accept transferred Claims or transfer Claims to icare or a third party.

SECTION C - Transition-In

5. Transition-In arrangements

5.1 Transition-In Plan

(a) The Claims Service Provider must, within the timeframe notified by icare acting reasonably, prepare and submit to icare for Approval a Transition-In Plan which includes, at a minimum, the following information:

(i) the Deliverables, Milestones and other activities the Claims Service Provider must perform to ensure that the Claims Service Provider will be onboarded satisfactorily and ready to deliver Services from the date specified in the Transition-In Plan, which for clarity may include the transfer of Claims having been completed by the Claims Service Provider in accordance with clause 6; and

(ii) any other requirements and processes notified by icare.

(b) The parties acknowledge that a draft of the Transition-In Plan has been prepared in the form attached as Schedule 12 ("Draft Transition-In Plan").

5.2 Transition of Services

(a) Each party must perform its Transition-In obligations during the Transition-In Period in accordance with the Transition-In Plan.

(b) During the Transition-In Period, the Claims Service Provider must:

(i) use best endeavours to identify and resolve, or assist icare in the resolution of, any problems encountered in the timely completion of its Transition-In obligations;

(ii) provide icare with progress reports as specified in the Transition-In Plan (or as otherwise required by icare) that describe in detail the current status of the Transition-In, including Deliverables provided and how the Claims Service Provider is tracking against relevant Milestones, and identify any actual or anticipated problems and propose solutions to those problems;

(iii) attend meetings with icare as specified in the Transition-In Plan or as required by icare. Ad hoc meetings may be requested by either party as the need arises. Both parties will work cooperatively to attend and participate in ad hoc meetings; and

(iv) meet relevant icare processes and requirements as notified by icare to the Claims Service Provider in relation to the carrying out of its obligations under 5.2(b)(i) to 5.2(b)(iii).

5.3 Acceptance of Transition-In

(a) The Claims Service Provider must provide all assistance reasonably requested by icare in connection with the Acceptance of Transition-In.

(b) icare (in consultation with the Claims Service Provider) will assess whether the Claims Service Provider has achieved the Acceptance Criteria to determine if the Claims Service Provider is fully onboarded, ready and able to provide the Services. The assessment will be in a format determined by icare in consultation with the Claims Service Provider and include assessment of whether the Claims Service Provider has achieved the Deliverables, Milestones, tests and Acceptance Criteria as set out in the Transition-In Plan.

(c) If icare's assessment reveals that the Acceptance Criteria:

(i) have all been achieved, icare will issue an Approval to that effect to the Claims Service Provider; or

(ii) have not all been achieved, then the Claims Service Provider must, at no cost to icare, do all things necessary to rectify any problems within a period specified by icare, acting reasonably, and icare will repeat the assessment in accordance with the Transition-In Plan.

(d) If:

(i) the Claims Service Provider fails to comply with clause 5.3(c); or

(ii) the Claims Service Provider fails to pass the repeat assessment referred to in clause 5.3(c),

then icare may:

(iii) set a new date for repeating the assessment (in which case clause 5.3(c) applies);

(iv) conditionally Accept Transition-In in accordance with clause 5.4; or

(v) reject the Transition-In and terminate the Contract under clause 59.2.

(e) icare is not liable to pay any amount conditional on Acceptance of Transition-In unless and until Acceptance of Transition-In has occurred in accordance with this clause 5.3 and the Transition-In Plan.

5.4 Conditional Acceptance

(a) icare may, at any time, conditionally Accept Transition-In, notwithstanding that the Acceptance Criteria have not been achieved, by giving the Claims Service Provider a notice that:

(i) includes a statement that icare Accepts Transition-In, subject to certain conditions which the Claims Service Provider must satisfy;

(ii) specifies the problems that prevent the Services from achieving the Acceptance Criteria;

(iii) specifies the remaining conditions which the Claims Service Provider must satisfy to achieve Acceptance for Transition-In; and

(iv) specifies the rectification work to be performed by the Claims Service Provider and the time period for performing such work.

(b) If the Claims Service Provider does not perform the rectification work or satisfy the conditions within the time frame specified in the notice, then icare may:

(i) set a new date for the assessment; or

(ii) reject the Transition-In, and terminate the Contract for cause under clause 59.2.

5.5 No deemed Acceptance

icare will not be deemed to have Accepted Transition-In by the use of the Services, or any other act or omission other than the provision of an Approval.

5.6 Responsibility

On and from the Services Commencement Date, the Claims Service Provider must accept full responsibility for provision of the Services in accordance with the requirements of this Contract.

SECTION D - Transfer of Claims

6. Transfer of Claims and Employers

6.1 Acknowledgement

The Claims Service Provider acknowledges that:

(a) icare wishes to advance the Workers Compensation Scheme Principles and that in exercising its opinion as to how that is achieved:

(i) icare may allocate Claims between itself, the Claims Service Provider and Other Claims Service Providers as it considers appropriate (taking into account any factors it considers relevant including performance and the nature of the applicable Claims); and

(ii) advancing the Workers Compensation Scheme Principles may involve the movement of certain Claims arising during the Term to icare or its nominee, or to other persons, including movements under clause 6.2; and

(b) the Claims Service Provider must cooperate in the transfer of Claims between icare and Other Claims Service Providers.

6.2 icare may transfer Claims

icare may, on one or more occasions during the Term, issue a notice requiring the Claims Service Provider to transfer some or all Claims to or from icare or any other person, including in the following circumstances:

(a) as part of the Transition-In;

(b) where clause 59.2(b)(i) applies;

(c) in respect of a cohort of Claims that icare wishes to be handled by icare, Other Claims Service Providers, Employers or other persons;

(d) where an Eligible Employer exercises choice to nominate a new Claims Service Provider with effect from their renewal date in accordance with the nomination period and process determined by icare;

(e) where there is a Change of Control of the Claims Service Provider;

(f) where icare considers that, as a result of any legislative change or change in the Workers Compensation Scheme Principles or due a change in government policy, or due to recommendation from SIRA, a transfer under this clause 6.2 is appropriate;

(g) pursuant to a Remediation Plan at any time; and

(h) where the Claims Service Provider is required to provide Disengagement Services pursuant to clause 60.1.

6.3 Obligation to Accept Claims transferred under clause 6.2

Where icare requires the Claims Service Provider to provide Services in respect of Claims that are proposed to be transferred from icare or an Other Claims Service Provider pursuant to clause 6.2, the Claims Service Provider must accept and give effect to the transfer of the Claims and will carry out such transfer in accordance with Schedule 7 (“Claims File Transfer”) and any requirements notified by icare to the Claims Service Provider.

6.4 Co-operation in relation to transferred Claims

(a) The Claims Service Provider must cooperate with icare, any Other Claims Service Provider and Employers where a Claim has been transferred to or from Other Claims Service Providers (or to or from icare), including allowing icare, the Receiving Claims Service Provider and the Employer access to any Records or other information concerning decision making relating to any of the Employer's Claims that remain with icare or a Transferring Claims Service Provider.

(b) A Transferring Claims Service Provider or Receiving Claims Service Provider may request icare to issue a notice of requirements where disputes arise in relation to this clause 6.4 and on such a request icare may issue a notice specifying how a dispute under this clause 6.4 is to be resolved. Nothing in this clause 6.4 requires the Claims Service Provider to provide an Employer with any information which the Employer is not lawfully entitled to receive.

6.5 Scope of appointment

(a) The Claims Service Provider acknowledges and agrees that:

(i) as at the Commencement Date, the Claims Service Provider is appointed as the category of Scheme Agent identified in item 6 of the Contract Details, being:

(A) generalist;

(B) specialist; or

(C) generalist with specialist capabilities,

the nature and requirements of which categories are described in clause 6.5(b) (each a "**CSP Category**");

(ii) the Claims Service Provider may have the opportunity, through an application and approval process to be determined by icare, to apply for the accreditation required to manage specialist or generalist Claims (as applicable) in the manner required under a different CSP Category, such process to be available at a time determined by icare but anticipated to be no earlier than 18 months after the Commencement Date;

(iii) if the Claims Service Provider receives the accreditation contemplated in clause 6.5(a)(ii), icare may elect, by written notice, to alter its appointment to the CSP Category that aligns with the scope of the Claims Service Provider's updated accreditations;

(iv) throughout the Term, it will manage the Claims allocated to it and perform the Services and its other obligations under this Contract in accordance with the requirements applicable to the CSP Category of its then-current appointment, as icare may evolve those requirements following consultation between the parties; and

(v) if icare considers, after consultation with the Claims Service Provider, that the Claims Service Provider is not managing Claims in the manner required under its CSP Category, then icare may alter the CSP Category to which the Claims Service Provider is appointed.

(b) For the purpose of this clause 6.5, the CSP Categories are described below, including by reference to the range of Claims they must be capable of managing, and the manner in which they must manage them:

Category	Non-Psych		Psych		WWHN, Fatality and Medically Complex	
	Manage?	Approach?	Manage?	Approach?	Manage?	Approach?
Generalist	Yes	In a general manner	Yes	In a general manner	Yes	With a tailored approach
Generalist with Specialist Capabilities	Yes	In a general manner	Yes	With a tailored approach	Yes	With a tailored approach
Specialist	No	N/A	Yes	With a tailored approach	No	N/A

where:

(i) references to “in a general manner” indicate a standard and undifferentiated approach to management of those Claims; and

(ii) references to “with a tailored approach” indicate a management approach that is distinct and differentiated from the approach that the Claims Service Provider takes to meet its obligations in relation to any types of Claim that it is required to manage “in a general manner” (where a distinct approach may include using separate resources and support structures, and must include dedicated case managers of appropriate experience),

which in each case, must be appropriate to facilitating the achievement of the Workers Compensation Scheme Principles and meeting the Claims Service Provider’s other obligations under the Contract with respect to those Claims.

Part 3 Core service description

Simplified outline of this Part:

This Part 3 contains:

- Section E – Service obligations; and
- Section F – Financial arrangements.

Section E sets out the Claims Service Provider's general obligations relating to the Services, including:

- the application of Performance Measures;
- the Claims Service Provider's duties and responsibilities of the Claims Service Provider as icare's agent;
- provisions relating to icare's provision, and the Claims Service Provider's use, of the Claims Technology Platform; and
- the framework for performance of Projects; and
- the framework for the implementation of improvements and innovation

Section F sets out the framework for payment of the Claims Service Provider's fees, payment of third parties and other financial and tax arrangements.

SECTION E - Service obligations

7. General provisions relating to Services

7.1 Customer engagement

The Claims Service Provider will at all times during the Term comply, and ensure its Personnel, any Key Input Provider (and its Personnel), and any Related Body Corporate involved in the performance of its obligations or delivery of the Services comply with Schedule 1 ("Customer Engagement & Claims Management Services").

7.2 Information relating to volume of Services

The Claims Service Provider agrees that any information relating to the volume of Services required or Claims provided to the Claims Service Provider prior to this Contract is indicative only and not binding on icare or its Personnel.

7.3 Performance of Services

(a) The Claims Service Provider will take all steps necessary to ensure:

(i) it has in place all Equipment and Personnel to enable the performance of the Services and the obligations under this Contract as required by the Contract and by Law and Regulatory Guidance;

(ii) it has the capability to meet the Targets and achieve all Performance Measures in each Reporting Period; and

(iii) it has the capability to perform the Services consistently with the Workers Compensation Scheme Principles and otherwise in compliance with its obligations under this Contract, including clause 2.

(b) The Claims Service Provider will, in performing the Services and its other obligations under this Contract:

(i) meet or exceed the timing requirements set out in this Contract or as required by Law and Regulatory Guidance; or

(ii) if no timing requirements are stipulated, perform the Services and its other obligations promptly.

7.4 Performance Measures

(a) The Claims Service Provider must ensure that the Services are conducted in a manner that meets or exceeds the Quality Measures and Operational Measures in each Reporting Period, during the Term.

(b) The Performance Measures applying to the Claims Service Provider's performance of the Services and the method of calculating and interpreting them are set out in Schedule 2 ("Remuneration") and Schedule 3 ("Performance Management & Governance").

7.5 Documentation

The Claims Service Provider must ensure that all of its systems and processes used to provide the Services are accurately and completely documented and that this Documentation is kept up to date at all times during the Term.

7.6 Adherence to Manuals, icare Operational Materials and Claims RACI

The Claims Service Provider must ensure that in performing the Services:

(a) it complies with any requirement, obligation or specification specified in the Manuals; and

(b) it complies with the icare Operational Materials and complies with, and at all times acts in accordance with, the Claims RACI.

8. Agency – duties and responsibilities

8.1 Claims Service Provider to represent itself as agent of icare

Subject to clause 28, in performing its obligations under this Contract, the Claims Service Provider must represent itself as agent of icare including in all dealings with Workers, Employers, Third Party Service Providers and any other persons.

8.2 Acknowledgement

The Claims Service Provider acknowledges and agrees that:

(a) it owes certain duties to icare, including fiduciary duties, to provide the Services:

(i) in good faith;

(ii) with due care and skill, and in accordance with Best Industry Practice;

(iii) in a timely, efficient and cost-effective manner; and

(iv) within the scope of its authority to act, and in accordance with the requirements, as set out in this Contract,

and that in performing its obligations under this Contract these duties are paramount;

(b) it will:

(i) perform its obligations under this Contract, and act in all respects in connection with the Scheme, including in its dealings with Workers, Employers and Third Party Service Providers in a manner which would not place the Claims Service Provider in a position where there is conflict between the Claims Service Provider's duties:

(A) as a fiduciary and its own interest or a duty to any third party, or

(B) as a fiduciary to two or more persons in the same transaction or matter,

without the prior Approval of icare; and

(ii) keep icare fully and promptly informed of all the matters that materially affect the Workers Compensation Scheme Principles and the performance of the Contract and include such matters as part of its regular reporting and meetings with icare as further described in Schedule 3 (“Performance Management & Governance”).

(c) the Claims Service Provider’s rights as an agent under the law of agency are varied by this Contract, including:

(i) the right to any payment for the performance of the obligations in this Contract is limited to those set out in clauses 13.1 and 13.2. The Claims Service Provider is responsible, at its own cost, for providing any accommodation, facilities, Equipment, furnishings, fixtures, Personnel and

support it needs to supply the Services in accordance with the requirements of this Contract;

(ii) the right for indemnity for expenses incurred by the Claims Service Provider and icare's obligations to bear the costs for expenses are limited to those rights described in clauses 14, 58.2 and 58.5;

(iii) any arrangements, written or otherwise, entered into by the Claims Service Provider with any Employer, Policyholder, Third Party Service Provider or any other person, for which this Contract does not provide authority for the Claims Service Provider to enter into as agent for icare, are not arrangements made as agent for icare; and

(iv) to avoid doubt, any arrangements, written or otherwise, entered into by the Claims Service Provider with any of its Personnel or Subcontractors for the purpose of delivering the Services are not arrangements made as agent for icare.

8.3 Restrictions on Claims Service Provider's authority

The Claims Service Provider does not have any authority to do any of the following in its capacity as a Scheme Agent:

(a) perform any act, or make any omission, which is not necessary or not incidental to the performance of its obligations under this Contract;

(b) make any false, misleading or deceptive statement or representation;

(c) breach any Law;

(d) make any representation or statement in a manner which a third party could reasonably believe was made:

(i) for or on behalf of icare in any role other than as acting for, or on behalf of, icare;

(ii) in relation to any of icare's functions that are described under Law, for which the Claims Service Provider has not been given express authority under this Contract, including:

(A) statements of current or future policy of icare or any other person; or

(B) that the Claims Service Provider is providing any services other than the Services; or

(C) that the Claims Service Provider is providing insurance;

(e) enter into contracts with Third Party Service Providers for services in relation to the Scheme other than as agent for icare, except to the extent permitted by clause 28; or

(f) conduct any litigation or arbitration proceedings as agent for icare (including filing a statement of claim or filing a defence), except as expressly set out in this Contract, or with the prior Approval of icare.

8.4 Ratification of acts beyond actual authority

icare will not be taken to have ratified any act or omission of the Claims Service Provider which was outside the actual authority of the Claims Service Provider, but which a third party claims was within the ostensible authority of the Claims Service Provider, unless:

(a) the Claims Service Provider has notified icare of such act or omission and such notice sets out the full facts and consequences on which the ratification is based; and

(b) the ratification is Approved by the icare Authorised Representative.

8.5 icare's obligations

To the extent permitted by Law, icare's obligations or liabilities as a principal under the Law of agency are varied as set out in this Contract.

8.6 icare's rights

(a) icare's rights under this Contract do not reduce, limit or restrict in any way any function, power, right or entitlement of icare under Law, including any rights icare has as principal under Law relating to agency.

(b) Nothing in this Contract restricts, hinders or prevents icare or its Personnel from performing their respective rights or functions under Law.

9. System and process

9.1 Claims Technology Platform

(a) icare will provide the Claims Technology Platform for the Term.

(b) The Claims Service Provider's access to and use of the Claims Technology Platform is governed by the terms of this Contract, including but not limited to this clause 9 and Schedule 9 ("Claims Technology Platform").

(c) The Claims Service Provider agrees to:

(i) use only the Claims Technology Platform (and not any other IT system of the Claims Service Provider or any other person) for the Services unless otherwise agreed with icare (including as agreed in a Special Condition);

(ii) use the Claims Technology Platform for the Services only in accordance with its access and user rights and for no other purpose;

(iii) co-operate with icare to implement or assist in the implementation of any initiatives and updates directed by icare in relation to or in connection with the Claims Technology Platform;

(iv) change the manner in which it is to perform the Services or any other obligation under this Contract where it is necessary to do so in order to use and interface with the Claims Technology Platform for the performance of

the Services following an update made to the Claims Technology Platform by icare from time to time; and

(v) ensure that its systems and any interfaces between its systems and the Claims Technology Platform meet the requirements of icare as set out in the Contract, including Schedule 9 ("Claims Technology Platform").

(d) Except as set out in this clause 9, the Claims Service Provider acknowledges and agrees that icare provides no warranty or representation about the suitability or fitness of the Claims Technology Platform for the Services or any other use.

(e) The Claims Service Provider must:

(i) promptly inform icare if it becomes aware of:

(A) any issues with the operation or maintenance of the Claims Technology Platform that materially adversely impact the Claims Service Provider's ability to provide the Services;

(B) any unauthorised access to the Claims Technology Platform or breach of user rights; and

(C) any loss or destruction of Data from the Claims Technology Platform;

(ii) not use any Claims Service Provider system that integrates with the Claims Technology Platform (**bolt-on system**) for the provision of the Services without prior icare Approval; and

(iii) promptly inform icare if it becomes aware of any issues with the operation or maintenance of an Approved bolt-on system that materially adversely impact the Claims Service Provider's ability to provide the Services.

(f) The parties agree that:

(i) a direction issued in relation to the implementation of any initiatives or updates relating to the Claims Technology Platform will be treated as a Direction issued under clause 39.1(a) and will be subject to clause 39; and

(ii) if an update to the Claims Technology Platform results in the Claims Service Provider changing the manner in which it is to perform the Services or any other obligation under this Contract, as contemplated in clause 9.1(c)(iv), the requirement to implement that change will be deemed to be a Direction to implement that change under and subject to clause 39.

(g) Except as contemplated in Section J- Directions and Change Management of this Contract, in no circumstances will icare be required to pay any fee or compensation to the Claims Service Provider in relation to the implementation of any initiatives or updates, whether proposed by icare or the Claims Service Provider, relating to the Claims Technology Platform.

9.2 System Requirements

The Claims Service Provider must:

(a) ensure, including take all steps necessary to ensure, that any Equipment, interfaces, and processes used to perform the Services interface and integrate with the Claims Technology Platform; and

(b) ensure that in providing the Services it does not knowingly adversely affect or alter the operation, functionality or technical environment of the Claims Technology Platform, without icare's prior Approval.

9.3 Malware control by Claims Service Provider

(a) The Claims Service Provider must use its best endeavours to detect and prevent any Malware from being introduced directly or indirectly by the Claims Service Provider or its Personnel, into (or sent from) any Deliverables or icare's systems, including but not limited to the Claims Technology Platform, including by:

(i) use of the most appropriate and up-to-date Malware detection software for preventing and detecting Malware;

(ii) implementing practices and procedures that are consistent with Best Industry Practice;

(iii) pro-actively monitoring known threats of Malware; and

(iv) informing icare of any Malware within the Claims Service Provider's environment that may affect icare and the steps necessary to avoid the introduction of Malware.

(b) If the Claims Service Provider becomes aware that any Malware is found to have been introduced into any Deliverables or icare's systems, then the Claims Service Provider must:

(i) notify icare immediately;

(ii) provide all information reasonably requested by icare in relation to the Malware, its manner of introduction and the effect the Malware has had or is likely to have;

(iii) take all necessary remedial action within the power or control of the Claims Service Provider to eliminate the Malware and prevent re-occurrence and rectify any consequences (to the extent that they are capable of rectification);

(iv) if the Malware causes a loss of Data or impacts the Data's availability, integrity, reliability or confidentiality, assist icare to mitigate the losses and restore the efficiency and/or Data;

(v) retain evidence and logs regarding the incident to help in determining the cause, damage and likely source; and

(vi) ensure that sufficient Claims Service Provider resources and technology are available to meet its obligations under this clause 9.3.

(c) If the Malware was introduced:

(i) by the Claims Service Provider or its Personnel; or

(ii) as a result of the Claims Service Provider's negligence or the Claims Service Provider failing to meet its obligations under this clause 9.3,

the Claims Service Provider must pay the costs and expenses reasonably incurred by icare in connection with the restoration activities contemplated by this clause 9.3.

(d) The Claims Service Provider acknowledges that:

(i) icare complies with the NSW Government Cyber Security Policy; and

(ii) if icare becomes aware that any information security risk (including Malware) experienced by the Claims Technology Platform may reasonably be expected to affect the Claims Service Provider's systems, then it will notify the Claims Service Provider as soon as practicable.

9.4 System Access

(a) The Claims Service Provider must provide any interface resource (including software, hardware or equipment) necessary to enable the Claims Service Provider's Equipment to interface with icare's equipment or systems.

(b) Any information provided via the interface resource for the purposes of clause 9.4(a) is deemed to be the Claims Service Provider's Confidential Information.

(c) The Claims Service Provider must comply with the following requirements when accessing any icare hosted systems using devices that are not issued by icare:

(i) access must be via icare's approved platform with multi-factor authentication;

(ii) icare's Data must not be copied or transferred away from the icare hosted system without icare's Approval; and

(iii) the devices used by the Claims Service Provider must have up-to-date operating system patches applied, and appropriate and up-to-date Malware detection software.

(d) The Claims Service Provider must:

(i) implement secure and strong encryption (or other security controls as reasonably agreed in advance in writing by the parties) to protect icare's Data whilst in transit and to the extent it is at rest in any form or location under the Claims Service Provider's control; and

(ii) without limiting clause 9.4(d)(i), ensure that its encryption algorithms remain current and up-to-date at all times in accordance with the then current guidelines for cryptography published by the Australian Signals Directorate (or if no such guidelines are published, in accordance with Best Industry Practice).

10. Approved Locations

(a) Subject to clause 10(b):

(i) the Claims Service Provider must, unless icare otherwise agrees or under clause 10(h), perform each Service only from the Approved Locations that have been Approved for that Service; and

(ii) prior to the Services Commencement Date, the Claims Service Provider must obtain Approval for all locations from which Services will be performed from the Services Commencement Date (other than those locations, if any, identified in item 8 which have already been Approved).

(b) If the Claims Service Provider has been providing claims management services to the Nominal Insurer under an agreement that is on foot immediately prior to the Commencement Date (a **Pre-Existing Agreement**), then for the period from the Services Commencement Date until 31 March 2023 (or such later date as icare notifies), the Claims Service Provider may perform Services from each location from which it performed services under the Pre-existing Agreement immediately prior to the Commencement Date (each a **Pre-existing Location**) provided that:

(i) the scope of activities performed at each Pre-existing Location must be substantially the same as the activities performed at that location immediately prior to the Commencement Date;

(ii) the Claims Service Provider must comply with all conditions and restrictions applicable to the provision of services from that Pre-existing Location under the Pre-existing Agreement or any approval or direction given under it; and

(iii) the Claims Service Provider must continue to apply security controls no less protective than those which applied in respect of the Pre-existing Location under the Pre-Existing Agreement.

(c) If the Claims Service Provider wishes to:

(i) designate a location as an Approved Location in respect of certain specified Services;

(ii) change the type of Services to be provided at an Approved Location; or

(iii) relocate the provision of certain Services from one Approved Location to another Approved Location,

then the Claims Service Provider must provide to icare a written proposal that identifies:

(iv) the specific location, including if it is located within or outside Australia;

(v) the Services to be performed at the proposed location and the Claims Service Provider Personnel who would perform the Services at the location;

(vi) in respect of a proposal for the provision of Services from a location outside Australia:

(A) full details of any Data which would be transferred, stored, processed, collected or accessed from outside of Australia, including the scope of that transfer, storage, collection or access and whether any of that Data would include Health Information, Personal Information, Records or Confidential Information of icare; and

(B) security measures which the Claims Service Provider would take to protect the Data; and

(vii) any other details requested by icare

(**Location Proposal**).

(d) On receipt of the Location Proposal, icare may:

(i) Approve the location as an Approved Location and for the Services to be provided from that location;

(ii) require the Claims Service Provider to meet with icare to discuss the Location Proposal; or

(iii) reject the location as an Approved Location.

(e) icare may, in giving its Approval under clauses 10(a) and 10(d), impose such conditions as it thinks fit and on receiving the Approval, the Claims Service Provider may provide the Services set out in the Location Proposal provided it complies with those conditions (if any) and only on the basis set out in the Location Proposal (except to the extent those details are inconsistent with the conditions).

(f) icare may, at any time by notice to the Claims Service Provider, withdraw its Approval for an Approved Location and require the Claims Service Provider to relocate the relevant Services to another Approved Location reasonably nominated by icare. icare will pay the Claims Service Provider's direct incremental and substantiated costs of relocation reasonably incurred except where its Approval is withdrawn under the following circumstances:

(i) in order for the Claims Service Provider to comply with any Laws or Regulatory Guidance applicable to the Claims Service Provider;

(ii) if, in icare's reasonable opinion, information provided to icare upon which icare relied in approving the relevant Approved Location was or has become inaccurate or incomplete;

(iii) the Claims Service Provider has breached any condition on which icare approved the relevant Approved Location; or

(iv) there is a security concern in relation to the Approved Location which, in icare's reasonable opinion, has a reasonable likelihood of adversely affecting the performance of those Services provided from that Approved Location.

(g) The Claims Service Provider:

(i) must as soon as reasonably practicable, comply with; and

(ii) will be responsible for any costs and expenses incurred by the Claims Service Provider in complying with,

icare's notice under clause 10(f).

(h) icare agrees to the Claims Service Provider working from and using Claims Service Provider resources outside the Approved Location for the provision of the Services as part of the Claims Service Provider's remote working practices, provided the Claims Service Provider has first obtained prior icare Approval of the remote working practices the Claims Service Provider will be using for the purposes of this clause.

11. Project Services

11.1 General

(a) The parties acknowledge and agree that:

(i) icare may, from time to time, request the Claims Service Provider to perform proposed Project Services;

(ii) the Claims Service Provider may, from time to time, propose Project Services and icare will at its discretion elect to request that the Claims Service Provider perform those proposed Project Services; and

(iii) in respect of a request by icare for proposed Project Services under this clause 11.1(a), the parties will follow the process set out in Schedule 4 ("Project Services Framework").

(b) The parties acknowledge and agree that, in accordance with the process set out in Schedule 4 ("Project Services Framework"), Project Services (and associated Deliverables) requested or proposed under this clause 11 may be subject to an alternative Intellectual Property Rights ownership and licensing model from that set out in clauses 33.1 to 33.4, except that Records, and Intellectual Property Rights in Records, are the property of icare, and will, on creation, vest in icare.

(c) In undertaking a Project Service requested or proposed under this clause 11, the Claims Service Provider must use a project management methodology which:

(i) complies with the principles of best practice project management;

(ii) improves the planning, strategy and management of projects;

(iii) enables execution of projects in such a way as to improve or to minimise any negative impact on Employers and Workers during the relevant project;

(iv) ensures icare has visibility of the Claims Service Provider's planning, strategy and management; and

(v) monitors the progress and the financial management of implementing Project Services; and

(vi) ensures a formal and structured method is used for managing projects.

(d) The Claims Service Provider will undertake each Project Service requested or proposed under this clause 11 in accordance with the applicable Statement of Work and the applicable Project Plan for the relevant Project Service and the applicable provisions set out in Schedule 4 ("Project Services Framework").

12. Co-operation and improvement

12.1 General

The Claims Service Provider must use every effort to work cooperatively and collectively with Other Claims Service Providers and icare to achieve the Workers Compensation Scheme Principles.

12.2 Claims Service Provider initiatives

(a) The Claims Service Provider may, from time to time, propose, develop and implement initiatives designed to improve the Services for the benefit of the Scheme, Workers and Employers, including as set out in Schedule 2 ("Remuneration").

(b) The Claims Service Provider must notify icare prior to the commencement of any improvement initiative and, unless icare notifies otherwise, any material changes post-commencement, including as part of its regular reporting and meetings with icare as further described in Schedule 3 ("Performance Management & Governance").

12.3 icare initiatives

(a) icare may, from time to time, direct the Claims Service Provider to participate in pilot programs or initiatives designed to improve the Services for the benefit of the Scheme, Workers and Employers. A direction issued under this clause will be treated as a Direction issued under clause 39.1(a) and will be subject to clause 39.

(b) Except as contemplated in Section J- Directions and Change Management of this Contract, in no circumstances will icare be required to pay any fee or compensation to the Claims Service Provider in relation to the implementation of any pilot programs or initiatives directed in accordance with this clause 12.3.

12.4 Innovation

(a) icare encourages the Claims Service Provider to be motivated and invest in innovation throughout the Term. To support this, icare has allocated an amount available throughout the Term to the "Annual Innovation and Strategic Investment Pool", as set out in and allocated in accordance with Schedule 2 ("Remuneration").

(b) icare will consider applications for innovation in relation to innovations that deliver benefits to the Scheme and that:

(i) have not previously been implemented successfully within the Scheme by icare or any Claims Service Provider; and

(ii) are expected to deliver measurable benefits (whether qualitative or quantitative) to icare, Workers and Employers.

(c) For the purpose of clause 12.4(b)(ii), a benefit may include an idea that would promote the Workers Compensation Scheme Principles.

(d) In agreeing to fund innovation, the parties agree that the Services to be provided to implement the particular innovation may be subject to an alternative Intellectual Property Rights ownership model from that currently agreed under clauses 33.1 to 33.4, except that Records, and Intellectual Property Rights in Records, are the property of icare, and will, on creation, vest in icare.

(e) icare may give notices and issue guidelines to the Claims Service Provider specifying how an application for innovation under this clause 12.4 is to be submitted and assessed.

SECTION F - Financial Arrangements

13. Financial Arrangements

13.1 Payment of Services

Subject to clause 13.2 and clause 59, for each Year (or part of a Year) in the Term, icare must pay to the Claims Service Provider the following Remuneration in accordance with the provisions in this Contract:

(a) the Fees;

(b) any amounts payable for a Project Service in accordance with clause 11; and

(c) any amounts payable under a Delivery Proposal that has been approved by icare in accordance with clause 40(d).

13.2 Withholding payment for Services

If icare disputes, acting reasonably, that the Services have been fully performed so as to meet the requirements of this Contract and provides reasonable evidence to the Claims Service Provider setting out the detail of the non-performance, it will pay for the part of the Services that have been fully performed and withhold the payments that relate to the disputed performance. Either party may refer the matter to be resolved under the dispute resolution procedure in clause 57.

13.3 Only amounts payable as Remuneration

The amounts payable under clause 13.1 are the only amounts payable to the Claims Service Provider as Remuneration for the Claims Service Provider performing all of the obligations under this Contract in respect of the Services during the Term.

13.4 Manage cash forecasting

The Claims Service Provider must assist icare as requested to determine the impact of the cash inflows and payments for the Scheme.

13.5 Undertake financial management reporting

The Claims Service Provider must, at a minimum, ensure that it has a financial management system that completely, accurately and in a timely manner records transactions, assets and liabilities managed on behalf of icare, and where required, interfaces with the Claims Service Provider's Claims system, and meets or exceeds the requirements set out in Schedule 5 (“Banking and Financial Management”).

13.6 Interest

(a) Interest will be payable by icare in respect of a delay of 90 Business Days or more in the assessment or payment of any amounts due to the Claims Service Provider, including expenses, Remuneration or other amount payable under this Contract, where the delay results from:

(i) a delay in receiving data from an Other Claims Service Provider; or

(ii) a delay in calculating the data by icare.

(b) Interest will be payable at the reference lending rate as expressed as a percentage per annum charged by Westpac Banking Corporation from time to time as published in the Australian Financial Review failing which it will be a similar rate selected by icare from a major Australian trading bank.

13.7 Remuneration may be recalculated

icare reserves the right to have any payment of Remuneration recalculated at any time prior to the sixth anniversary of the termination or expiry of this Contract if there are errors in the data on which the calculation is based, if those errors were caused or contributed to by the Claims Service Provider.

13.8 Payments by EFT

All payments made by icare under this Contract will be made by electronic funds transfer into an Australian bank account nominated by the Claims Service Provider.

13.9 Interim Payments and Final Adjustment

(a) For the purposes of clause 13.1, icare will make Interim Payments of the Claims Service Provider’s share of the Fees in accordance with Schedule 2 (“Remuneration”).

(b) icare will pay to the Claims Service Provider any positive Final Adjustment of the Claims Service Provider’s aggregate share of the Fees or set off that amount against any amount owing to icare in accordance with clause 21. The payment will be made within 20 Business Days of the date on which icare determines the Final Adjustment.

(c) The Claims Service Provider must pay to icare any negative Final Adjustment to icare in accordance with Schedule 2 ("Remuneration") within the time period stipulated in that Schedule or, if no time period is stipulated, within 20 Business Days of the date on which icare advises the Claims Service Provider of the Final Adjustment.

13.10 icare payments

(a) The Claims Service Provider acknowledges that any payment obligations of icare under this Contract may be satisfied by icare procuring payment by another party.

(b) icare may require any payments required to be made by the Claims Service Provider to icare (including any payment obligations arising under clause 13.9) to be made to its nominee.

14. Third Party SP Payments

14.1 Third Party SP Payments to be paid by Claims Service Provider

The Claims Service Provider will pay, on behalf of icare, all Third Party SP Payments for which there is a Qualifying Invoice in accordance with this Contract.

14.2 Participation in outsourcing

If icare enters into a general arrangement for the payment or processing of any Third Party SP Payment then the Claims Service Provider will participate in that arrangement as required by icare.

14.3 Qualifying invoice

(a) A Qualifying Invoice means a Tax Invoice for any of the following services provided by a Third Party Service Provider, where that invoice meets the requirements set out in clause 14.3(b):

(i) services that were acquired by the Claims Service Provider acting as agent for icare;

(ii) services that were acquired by the Claims Service Provider within the scope of its authority under this Contract; or

(iii) services that were acquired by a Worker exercising his or her rights at Law.

(b) In all cases, a Qualifying Invoice must meet all of the following requirements:

(i) it is for services that have been completed in accordance with the obligations placed on the Third Party Service Provider;

(ii) if it is for a Benefit or entitlement, then that amount must be properly claimable;

(iii) it is for an amount that is due;

(iv) it is not a payment for services completed by a Third Party Service Provider that has already been paid for;

(v) it is properly calculated in accordance with any Law;

(vi) it is supported by a Tax Invoice (unless Law does not require a Tax Invoice in order to be reimbursed) addressed to the Claims Service Provider in its capacity as agent for icare, which includes:

(A) the ABN advised by icare; and

(B) the 3 digit extension to indicate the GST branch of icare managed by the Claims Service Provider;

(vii) it is supported by any Documentation required by and otherwise meets all requirements set out in the Manuals; and

(viii) it does not include any amount that is in excess of an amount originally quoted by the Third Party Service Provider for the service, or is for default interest or other cost associated with late or non-payment of the invoice.

14.4 Payment of Qualifying Invoices

The Claims Service Provider will pay Qualifying Invoices by drawing on the Payment Account within the timeframes set out in the Schedules and the Manuals (or any shorter timeframe as required by Law or Regulatory Guidance).

14.5 Reimbursement of payments for non Qualifying Invoices

Following a Demand from icare, the Claims Service Provider must reimburse icare for any payment made by icare for which there was not a Qualifying Invoice.

15. Payments of Benefits and Entitlements

15.1 Payment to Employers, Workers and Third Party Service Providers

The Claims Service Provider will pay to the relevant Employer, Worker or Third Party Service Provider their Benefits and entitlements on behalf of icare, in accordance with this Contract and the Law and Regulatory Guidance.

15.2 Reimbursements of Benefits not properly paid

Following a Demand from icare (such Demand to include sufficient information to enable the Claims Service Provider to understand the nature and quantum of the Demand), the Claims Service Provider must promptly reimburse icare for any payment of any Benefit which was paid other than in accordance with the requirements of the Contract or the relevant Law, even if the Claims Service Provider is unable to immediately obtain repayment of the Benefit from the relevant Employer, Worker or Third Party Service Provider.

15.3 Adjustment of Reimbursements

If the Claims Service Provider has reimbursed icare under clause 15.2, and subsequently obtains the correct payment as agent for icare, then, by providing notice to icare, it may reconcile the amounts paid and remitted and require icare to pay any overpayment back to the Claims Service Provider.

15.4 Reasonable diligence

Nothing in this clause 15 is intended to make the Claims Service Provider liable for errors in information provided to the Claims Service Provider which the Claims Service Provider could not detect using reasonable diligence.

16. Collection of moneys due to icare

The Claims Service Provider will promptly collect any moneys from Employers and any other person from whom moneys are due to icare in connection with Claims being managed as part of the Services, including:

(a) any applicable GST; and

(b) in relation to those Claims:

(i) any amount repaid by an Employer under section 160 of the 1987 Act;

Note: Section 160 imposes an obligation on an Employer to remit excess funds to the insurer of a Policy.

(ii) any money authorised to be paid into the WCIF under the 1987 Act, or regulation, as required by icare; and

(iii) any money recovered under section 151Z of the 1987 Act.

Note: Section 151Z relates to repayment of compensation received by a worker in circumstances where the worker also recovers damages from a person other than the worker's employer.

17. Basis for holding moneys

17.1 Moneys held as bailee

The Claims Service Provider holds any moneys, including cheque, negotiable instruments or other form of payment, received from Workers, Employers, Third Party Service Providers, any Government Agency or any other person as bailee only and any such moneys paid into or received into an account are held on trust by the Claims Service Provider for the benefit of icare.

17.2 No security interests or encumbrances

The Claims Service Provider does not have, and must not permit the creation of, any general or particular security interest or other form of encumbrance or any trust or other interest over any moneys, including cheques or other form of payment, that the Claims Service Provider received as agent for icare.

17.3 Obligations under the 1987 Act

The Claims Service Provider acknowledges and agrees that icare's obligation to pay any moneys to the Claims Service Provider is subject to all applicable Laws, including, in relation to the provision of Services to icare:

(a) section 154B(5) of the 1987 Act; and

(b) section 154E(2) of the 1987 Act.

Note: Section 154E(2) determines the purposes for which assets of the Relevant Fund may be applied. Section 154B(5) states that liabilities of the Nominal Insurer as insurer under a Policy can only be satisfied from the Relevant Fund and are not liabilities of the state of NSW, icare or any authority of the state of NSW.

17.4 Remission of moneys

The Claims Service Provider must remit any moneys (including cheques or other forms of payment) to icare's account as soon as received in accordance with Schedule 5 ("Banking and Financial Management") and no later than within two Business Days after receipt, unless otherwise Approved by icare.

17.5 Procedures in respect of handling moneys

The Claims Service Provider must follow the procedures in the Contract in respect of all payments, the handling of moneys, including cheques and other forms of payment, and Internal Controls in respect of moneys and its systems that account for or process payments.

18. Banking arrangements

18.1 Use of Approved banking facilities

The Claims Service Provider must only use the banking facilities Approved by icare or as set out in the Manuals.

18.2 Bank fees

The Claims Service Provider will only be liable for bank fees to the extent set out in the Manuals.

19. GST and other taxes

19.1 Amounts in this Contract are GST exclusive

All consideration provided, or to be provided, under this Contract and all amounts set out in this Contract are exclusive of GST, unless specifically stated to be inclusive of GST.

19.2 Payment of GST

For the purposes of this Contract:

(a) "**GST**" and any other terms used in GST Law that are capitalised in this Contract have the meaning given to those terms by the GST Law, unless the context provides otherwise;

(b) if the GST Law treats part of a supply as a separate supply for the purpose of determining whether GST is payable on that part of the supply or for the purpose of determining the period to which that part of the supply will be attributable, such part of the supply will be treated as a separate supply for the purpose of this clause 19.2, and this Contract;

(c) subject to clause 19.5, if GST is or becomes payable by the supplier on a supply made under or in connection with this Contract, an additional amount is payable by the party providing consideration for the supply (**Recipient**) equal to the amount of GST payable on that supply (**Additional Amount**); and

(d) the Additional Amount payable under clause 19.2(c) is payable to the supplier at the same time, to the same extent and in the same manner as the GST-exclusive consideration for the supply, and the supplier must provide the Recipient with a Tax Invoice as a precondition of payment of the Additional Amount (unless the Recipient has issued or is required to issue a Recipient Created Tax Invoice).

19.3 GST refunds, credits and further amounts

Unless specifically provided for in this Contract, if for any reason (including the occurrence of an Adjustment Event) the amount of GST payable on a supply (taking into account any decreasing or increasing Adjustments in relation to the supply, but disregarding the rules about Excess GST) varies from the Additional Amount payable by the Recipient under clause 19.2(c):

(a) the supplier must provide a refund or credit to the Recipient, or the Recipient must pay a further amount to the supplier, as appropriate;

(b) the refund, credit or further amount (as the case may be) will be calculated by the supplier in accordance with the GST Law; and

(c) the supplier must notify the Recipient of the refund, credit or further amount within ten Business Days after becoming aware of the variation to the amount of GST payable. If there is an Adjustment Event in relation to the supply, the requirement for the supplier to notify the Recipient will be satisfied by the supplier issuing to the Recipient an Adjustment Note within ten Business Days after becoming aware of the occurrence of the Adjustment Event.

19.4 Reimbursements

Notwithstanding any other provision in this Contract, if an amount payable under or in connection with this Contract (whether by way of reimbursement, indemnity or otherwise) is calculated by reference to an amount incurred by a party, whether by way of cost, expense, outlay, disbursement or otherwise (**Amount Incurred**), the amount payable must be reduced by the amount of any Input Tax Credit to which that party (or the representative

member of that party's GST group) is entitled in respect of that Amount Incurred, and then increased in accordance with clause 19.2, to the extent that clause applies.

19.5 Claims Service Provider to comply with tax obligations of the Nominal Insurer

The Claims Service Provider will comply with any and all tax obligations of the Nominal Insurer, on behalf of the Nominal Insurer, in respect of the Claims Service Provider's files, as is set out in Schedule 5 ("Banking and Financial Management"), the Manuals and as may be notified to the Claims Service Provider by icare, from time to time.

19.6 Particular tax obligations of icare

Without limiting clause 19.5, the tax obligations referred to in that clause include:

(a) obtaining, issuing and retaining proper and correct Tax Invoices in respect of all relevant transactions;

(b) deducting Pay As You Go (**PAYG**) tax from payments to Workers and others (where appropriate);

(c) such other obligations as icare may require the Claims Service Provider to carry out on its behalf during the Term; and

(d) providing other information relating to taxation matters as icare may reasonably require.

20. Invoices

20.1 Tax Invoices and Recipient Created Tax Invoices

(a) icare will calculate any amount due to the Claims Service Provider under clause 13.1. icare will use every effort to provide such calculations within 45 Business Days of the end of the month in which the payment became due.

(b) To the extent that clause 20.4 does not apply, the Claims Service Provider:

(i) will then promptly provide to icare a Tax Invoice for the amounts referred to in clause 20.1(a); and

(ii) will provide a Tax Invoice to icare for any other amount payable to the Claims Service Provider within ten Business Days of the end of the month in which the payment became due.

(c) To the extent that clause 20.4 applies, icare:

(i) will then promptly issue a Recipient Created Tax Invoice for the amounts referred to in clause 21.1(a); and

(ii) will issue a Recipient Created Tax Invoice for any other amount payable to the Claims Service Provider within ten Business Days of the end of the month in which the payment became due.

(d) All Tax Invoices and Recipient Created Tax Invoices must be itemised to the level of detail set out in the Manuals.

20.2 Payment of Tax Invoice and Recipient Created Tax Invoice

(a) icare will, subject to clause 17.3, pay the Tax Invoice issued by the Claims Service Provider within ten Business Days of receipt of a correctly rendered Tax Invoice that sets outs:

(i) the amount to be paid by icare, together with any substantiating material required; and

(ii) such other information as icare reasonably requires.

(b) icare will, subject to clause 17.3, pay the Recipient Created Tax Invoice within ten Business Days of its issuance.

(c) Invoices issued by the Claims Service Provider should be submitted to the email address for icare set out in clause 61.2.

20.3 Revision of Fee calculations

(a) If either icare or the Claims Service Provider becomes aware of an error in the calculation of any fees or Remuneration paid or payable under this Contract then that party must immediately notify the other party of the error.

(b) icare may:

(i) issue a further Recipient Created Tax Invoice, an amended Recipient Created Tax Invoice or a Recipient Created Adjustment Note;

(ii) require the Claims Service Provider to issue a further Tax Invoice, an amended Tax Invoice or an Adjustment Note, as the case may be; and/or

(iii) subject to clause 19.3, require the Claims Service Provider to refund any overpayment within ten Business Days of notice given in accordance with clause 20.3(a).

20.4 Recipient Created Tax Invoices

(a) This clause 20.4 applies in respect of Specified Supplies made by the Claims Service Provider.

(b) icare can, on behalf of the Nominal Insurer issue Recipient Created Tax Invoices in respect of the Specified Supplies which identify the Nominal Insurer as the recipient of the Specified Supplies.

(c) The Claims Service Provider must not issue Tax Invoices in respect of the Specified Supplies.

(d) The Claims Service Provider acknowledges that it is registered for GST and that it will notify icare if it ceases to be registered.

(e) icare acknowledges that the Nominal Insurer is registered for GST and that it will notify the Claims Service Provider if it ceases to be registered for GST or if it ceases to satisfy any of the requirements of Goods and Services Tax: Recipient

Created Tax Invoice Determination 2017 for Agricultural Products, Government Related Entities and Large Business Entities under the GST Act.

20.5 Tax Invoices for penalty repayments

A penalty referred to in clause 49.5, if imposed, must be invoiced by icare on a separate Tax Invoice and is payable by the Claims Service Provider within ten Business Days of receipt of the Tax Invoice.

21. Set-Off

21.1 Amounts which may be deducted as a set off

icare may deduct from the Financial Security, the Remuneration and/or any amount payable by icare to the Claims Service Provider any amount which:

(a) the Claims Service Provider must reimburse icare or against which it indemnifies icare (including any indemnity arising under clause 49.5);

(b) the Claims Service Provider owes to icare;

(c) icare has paid (or has procured to be paid) on the Claims Service Provider's behalf; or

(d) is a liability that is payable by the Claims Service Provider to icare,

whether under this Contract or otherwise, and will provide the Claims Service Provider with details of the deduction.

21.2 Recovery after set off

Nothing in this clause 21 affects icare's right to recover from the Claims Service Provider the whole of the debt or any balance that remains owing after any deduction or offset, including the right to recover such debt from the Financial Security.

21.3 Expenditure of moneys due to Claims Service Provider to rectify breach of Contract

icare will be entitled to expend any moneys due to the Claims Service Provider to make good any breach by the Claims Service Provider of any provision of this Contract and deduct such amounts from either:

(a) any amount that may be payable to the Claims Service Provider under this Contract, or

(b) the Financial Security,

provided that:

(c) icare will not be entitled to expend any moneys unless icare has first given the Claims Service Provider not less than 20 Business Days (unless otherwise provided in this Contract) notice of the breach (such notice to include reasonable details of the breach) and of its intention to make the expenditure; and

(d) the Claims Service Provider has not remedied the breach within that period.

Part 4 Conduct and ancillary obligations

Simplified outline of this Part:

This Part 4 contains:

- Section G – Compliance;
- Section H – Third Party Service Providers, subcontracting and personnel; and
- Section I – Intellectual Property, privacy and confidentiality.

Section G sets out the Claims Service Provider's general compliance obligations, including management of conflicts and compliance with laws and policies, and the application of a performance guarantee and/or financial security.

Section H sets out the Claims Service Provider's obligations regarding its management of Third Party Service Providers, subcontractors, Key Input Providers, and Personnel. For the purpose of this section:

- Subcontractor covers a subcontractor or agent engaged by the Claims Service Provider to fulfil some of the Claims Service Provider's obligations to perform the Services;
- Key Input Providers include Service Companies and other third parties who support the Claims Service Provider's performance of the Contract in a significant way (including by providing Personnel), and attract tighter controls around engagement, including the need for icare's Approval; and
- Third Party Service Providers are third parties engaged by icare (as Panellists or otherwise), by the Claims Service Provider (as icare's agent, unless otherwise instructed or permitted by icare), or by the relevant Worker in certain circumstances, to perform certain activities required for the effective management of Claims (e.g. preparing medico-legal reports or investigation reports and providing workplace rehabilitation services) which fall outside the scope of the Claims Service Provider's Services. If icare maintains a Panel of such third parties, it may direct the Claims Service Provider to engage those Panel members.

Section I sets out provisions regarding IP, privacy and confidentiality, including ownership and licensing of IP, controls around use and disclosure of confidential information (including under GIPA), and the protection of personal information.

SECTION G - Compliance

22. Claims Service Provider's general obligations

22.1 Must notify corporate changes

The Claims Service Provider must notify icare within ten Business Days of any of the following occurring to the Claims Service Provider, any of its holding companies or the Guarantor:

(a) a change to the composition of the board of directors that results in a change to the control of the board of directors;

(b) any single transaction or series of connected transactions resulting in a change exceeding 20% of the voting shares; or

(c) any Change of Control.

22.2 Conflict of interest - general

(a) The Claims Service Provider warrants that, to the best of its knowledge after making diligent inquiries, at the date of signing this Contract, no Conflict exists or is likely to arise in the performance of its obligations under this Contract by itself or any of its Personnel or a Service Company.

(b) The Claims Service Provider represents and warrants that throughout the Term it will use every effort to ensure that:

(i) none of its Related Bodies Corporate will have; and

(ii) neither the Guarantor nor any of the Guarantor's Related Bodies Corporate will have,

any direct or indirect control over, or any arrangement which directly or indirectly provides any of them control over more than 5% of the voting shares in, any other body corporate which is an Other Claims Service Provider or Third Party Service Provider, without prior notice to icare.

(c) If, during the Term, a Conflict arises, or appears likely to arise, the Claims Service Provider must:

(i) notify icare immediately;

(ii) make full disclosure of all relevant information relating to the Conflict and setting out the steps the Claims Service Provider proposes to take to resolve or otherwise deal with the Conflict; and

(iii) take such steps as have been proposed by the Claims Service Provider, or at the discretion of icare, icare requires to resolve or otherwise deal with the Conflict.

(d) If the Claims Service Provider fails to notify icare under this clause 22.2, or is unable or unwilling to resolve or deal with the Conflict as required by icare, icare

may immediately terminate this Contract for cause under clause 59.2 and pursue all remedies available to it under this Contract and at Law for the Claims Service Provider's material breach of this Contract.

22.3 Conflicted services

(a) Subject to clause 22.3(b), the Claims Service Provider must:

(i) not use any:

(A) information obtained by it in respect of Employers or Claims in performing its obligations under this Contract; or

(B) other knowledge gained as a result of its role as a Scheme Agent (except to the extent that knowledge is publicly available without breach of an obligation of confidence owed to icare, or generally known by persons skilled in the handling of workers compensation claims),

for any purpose that does not relate to the provision of the Services or the performance of its obligations under this Contract, except as Approved or otherwise required by icare;

(ii) not make any profit from any of icare's property, including icare's Confidential Information and icare Material without the prior Approval of icare; and

(iii) must not, during the Term, use the existence of this Contract or the Records to promote the distribution of any general insurance product to an Employer who is a client of icare, without the prior Approval of icare.

(b) Unless otherwise prohibited by icare, the Claims Service Provider may provide products, services, or benefits to an Employer that relate to work health and safety risk management services or workers compensation claims management services, provided that:

(i) the provision of the product, service or benefit (as applicable) does not result in any costs to the Relevant Fund;

(ii) the value of the benefit provided by the Claims Service Provider relates directly to the value of the product or service provided or to be provided;

Example: it would be a breach of this clause if the Claims Service Provider (not acting in its capacity as a Scheme Agent) cross-subsidised fees payable by an Employer for the provision of advice on how to reduce work safety risks because of remuneration receivable in its capacity as a Scheme Agent by reason of the number of Claims made under an Employer's policy.

(iii) any payment made by the Claims Service Provider to an Employer is in relation to a product, service or benefit under, or in connection with, the WH&S and Workers Compensation Legislation (or, where the Claims Service Provider provides worker compensation claims management

services in a State or Territory other than NSW, is in relation to a product, service or benefit under, or in connection with the workers compensation Laws in that other State or Territory) and is able to be fully substantiated as being a payment for this purpose; and

(iv) the Claims Service Provider maintains Documentation, books, accounts and Records (or obtains reasonable access for icare to Documentation, books, accounts and Records held by other persons) showing compliance with these requirements and which can be audited under clause 46.

(c) The parties agree that icare will acquire Services from the Claims Service Provider, on the condition that the Claims Service Provider must not:

(i) enter into any contract, understanding or arrangement in respect of insurance, or insurance brokerage, policy or Claims Management or similar services with any Employer for which it provides any services which conflicts with the Services under this Contract;

Example: If the Claims Service Provider had been managing Claims under this Contract in respect of a Policy held by an Employer, and the Employer subsequently became a Self-Insurer, there would be a conflict with the Services if the Claims Service Provider agreed to provide services similar to the Services to the Employer by redeploying resources which had been used to provide services under this Contract where there has not been a suitable intervening break between roles.

Example: The provision of general insurance services to an Employer would not in itself give rise to a conflict unless there is a breach by the Claims Service Provider of clause 22.3(a).

(ii) engage as a Third Party Service Provider any service providers in which it has either a direct or indirect control, interest, equity or share; or

(iii) provide, directly or through its Personnel or a Related Body Corporate, any service which is to be paid for by icare as a Third Party SP Payment,

without the prior Approval of icare.

(d) The Claims Service Provider acknowledges that:

(i) a breach of this clause 22.3 by the Claims Service Provider; or

(ii) a failure by any Related Body Corporate or a Key Input Provider to conduct itself consistently with the obligations imposed on the Claims Service Provider under this clause 22.3,

entitles icare to treat that action as a breach by the Claims Service Provider under this Contract and, without limiting icare's rights under this Contract, to terminate this Contract for cause under clause 59.2.

23. Laws and policies

23.1 Compliance with laws

The Claims Service Provider must obtain and maintain any licences, authorisations, consents, Approvals and permits required by applicable Laws and Regulatory Guidance, to provide the Services and to perform its obligations under this Contract.

23.2 Services to be provided in accordance with law and policies

The Claims Service Provider must, at all times, in carrying out the Services and performing its obligations under this Contract, comply with:

(a) all applicable Laws, including the WH&S and Workers Compensation Legislation;

(b) any:

(i) other regulatory guidance, rules, directions or orders, reporting requirements or standards of practice issued or published by SIRA or other regulatory body that are relevant to the Services; or

(ii) codes of conduct (whether mandatory or voluntary in their application) that are relevant to the Services;

(**Regulatory Guidance**), unless required otherwise by icare;

(c) any icare Policies notified by icare to the Claims Service Provider in writing, including but not limited to the:

(i) Complaints Policy;

(ii) Complaints Guidelines;

(iii) Complex Customer Circumstances Guidelines;

(iv) Information Security – Supplier Information Security Standard;

(v) Supplier Information Security Standard Guidelines;

(vi) Information Systems Security Standard; and

(vii) Information Classification Standard.

(d) New South Wales government policies that are relevant to the provision of the Services as notified by icare from time to time, including but not limited to:

(i) NSW Procurement Policy Framework; and

(ii) NSW Government Procurement: SME and Regional Policy.

24. Compliance with Modern Slavery Laws

24.1 Compliance

(a) The Claims Service Provider must comply with, and ensure all of its Personnel and their suppliers comply with, Modern Slavery Laws.

(b) The Claims Service Provider must take reasonable steps to ensure that all subcontracts that relate to the Services or the whole or any part of this Contract contain provisions no less protective than this clause 24.

(c) The Claims Service Provider warrants that, as at the Commencement Date, neither the Claims Service Provider, any entity that it owns or controls or, to the best of its knowledge, any Subcontractor, has been convicted of a Modern Slavery Offence.

24.2 Information

(a) In this clause 24, "**Information**" may include (as applicable) information as to any risks of, actual or suspected occurrences of, and remedial action taken in respect of, Modern Slavery but excludes Personal Information.

(b) The Claims Service Provider must:

(i) provide to icare any information and other assistance, as reasonably requested by icare and in the form required by icare, to enable icare to meet any of its obligations under the Modern Slavery Laws, including:

(A) cooperating in any Modern Slavery audit undertaken by icare (including by a third party on behalf of the icare) or the NSW Audit Office; and

(B) providing reasonable access to icare's or NSW Audit Office's auditors to interview the Claims Service Provider's Personnel;

(ii) within seven days of providing a Modern Slavery Statement to the Commonwealth, provide a copy of that Modern Slavery Statement to icare; and

(iii) notify icare as soon as it becomes aware of either or both of the following:

(A) a material change to any of the Information it has provided to icare in relation to Modern Slavery; and

(B) any actual or suspected occurrence of Modern Slavery in its operations or supply chains (or those of any entity that it owns or controls).

(c) The Claims Service Provider must, during the Term and for a further period of seven years:

(i) maintain; and

(ii) upon icare's reasonable request, give icare access to, and/or copies of,

a complete set of records in the possession or control of the Claims Service Provider to trace, so far as practicable, the supply chain of all goods and services provided under this Contract and to enable icare to assess the Claims Service Provider's compliance with this clause 24.

24.3 Modern Slavery due diligence

The Claims Service Provider must take reasonable steps to ensure that:

(a) Modern Slavery is not occurring in the operations and supply chains of the Claims Service Provider and any entity that it owns or controls; and

(b) it does not use, nor procure, any goods, plant, equipment or other materials and work or services that are the product of Modern Slavery.

24.4 Response to Modern Slavery incident

(a) If the Claims Service Provider becomes aware of any actual or suspected occurrence of Modern Slavery in its operations or supply chains (or in those of any entity that it owns or controls), the Claims Service Provider must take reasonable steps to respond to and address the occurrence in accordance with the Claims Service Provider's internal Modern Slavery strategy and procedures and any relevant policies, codes and standards (including any code of practice or conduct) or other guidance issued by any relevant Government Agency.

(b) Any action taken by the Claims Service Provider under clause 24.4(a) will not affect any rights of icare under this Contract, including its rights under clause 24.5.

24.5 Termination on ground of Modern Slavery

Without limiting any other right or remedy of icare under this Contract or at Law, icare may in its sole discretion terminate this Contract upon notice with immediate effect and without any requirement to pay compensation in respect of such termination (other than payment for work performed by the Claims Service Provider under this Contract and unpaid up until the date of termination), if:

(a) the Claims Service Provider fails to disclose to icare, prior to execution of this Contract, that the Claims Service Provider, or any entity owned or controlled by the Claims Service Provider, has been convicted of a Modern Slavery Offence;

(b) the Claims Service Provider, or any entity owned or controlled by the Claims Service Provider, is convicted of a Modern Slavery Offence during the Term;

(c) in icare's reasonable view, the Claims Service Provider has failed to notify icare as soon as it became aware of an actual or suspected occurrence of Modern Slavery in its operations or supply chains (or in those of any entity that it owns or controls);

(d) in icare's reasonable view, the Claims Service Provider has failed to take reasonable steps to respond to and address an actual or suspected occurrence of Modern Slavery in its operations or supply chains (or in those of any entity that it owns or controls); or

(e) in icare's reasonable view, the Claims Service Provider has otherwise committed a substantial breach (including multiple minor (non-trivial) breaches) of clause 24.1 or clause 24.2.

25. Compliance in procurement

25.1 Small and Medium Enterprises and Regional Procurement Policy

If item 15 of the Contract Details states that this clause 25.1 applies, the Claims Service Provider will:

(a) promptly following the Commencement Date provide its draft SME and Local Participation Plan to icare for Approval; and

(b) use best endeavours to comply with the SME and Local Participation Plan (once Approved).

25.2 Small Business Shorter Payment Terms Policy

If item 15 of the Contract Details states that this clause 25.2 applies:

(a) in any subcontract between the Claims Service Provider and a Small Business acting as a Subcontractor that is wholly or partly for the provision of goods or services for the purposes of this Contract (whether or not the subcontract was entered into before or after the date of this Contract), the Claims Service Provider must:

(i) identify those direct subcontractors and inform them of the Small Business Shorter Payment Terms Policy;

(ii) include in the subcontract a clause which requires the Claims Service Provider to pay the Small Business (for goods or services provided for the purposes of this Contract) within 20 Business Days following the receipt by the Claims Service Provider of a correctly rendered invoice from the Small Business; and

(iii) pay the Small Business:

(A) in accordance with the clause included in the subcontract pursuant to clause 25.2(a)(ii) above; or

(B) if SIRA requires the Claims Service Provider to pay the Small Business within a time period shorter than that contemplated in clause 25.2(a)(ii), within that shorter period.

(b) the Claims Service Provider must provide periodic reporting to icare on the Claims Service Provider's payment performance under clause 25.2(a)(iii) above. Unless otherwise required by icare in writing, the frequency of such periodic reporting should be quarterly as part of the reports referred to in clause 25.3; and

(c) the Claims Service Provider agrees that if it is the subject of a complaint in relation to its compliance with this clause 25.2 or the associated payment terms of the subcontract, it will not take any prejudicial action against the complainant due to a complaint being made or due to any investigation or inquiry by icare in relation to the complaint.

25.3 SME Policies

If any of the SME Policies apply, the Claims Service Provider must provide icare with a quarterly report containing details of the Claims Service Provider's compliance with the SME Policies, including (to the extent that the SME Policies apply):

(a) the SMEs (as defined in the SME Policies) engaged in the Services or as Third Party Service Providers;

(b) the amounts paid to any such SMEs;

(c) the Claims Service Provider's compliance with the SME and Local Participation Plan; and

(d) such other matters required under the SME Policies.

25.4 Aboriginal Participation

(a) If item 15 of the Contract Details states that this clause 25.4 applies, the Claims Service Provider:

(i) must promptly following the Commencement Date provide its draft Aboriginal Participation Plan to icare for Approval;

(ii) must comply with the Aboriginal Participation Plan (once Approved) and all relevant Aboriginal participation and quarterly and final reporting requirements under the Aboriginal Procurement Policy and clause 25.4(b);

(iii) acknowledges and agrees that Training Services NSW has established the Aboriginal participation fund to receive payments when the Claims Service Provider does not meet contracted Aboriginal participation requirements; and

(iv) acknowledges and agrees that where the Claims Service Provider does not meet its Aboriginal participation requirements under this Contract, icare may, in accordance with the Aboriginal Procurement Policy, withhold payments due to the Claims Service Provider or seek payment as a debt payable by the Claims Service Provider to icare pursuant to this Contract and direct the funds to an account held by Training Services NSW.

(b) The Claims Service Provider's compliance with the Aboriginal Procurement Policy includes identifying (to the extent that the Aboriginal Procurement Policy applies) the:

(i) Aboriginal-owned businesses engaged to perform the Services under this Contract or as Third Party Service Providers;

(ii) the Claims Service Provider's compliance with the Aboriginal Participation Plan; and

(iii) amounts paid to any Aboriginal owned businesses under this Contract.

(c) If, as at the Commencement Date, the Claims Service Provider is an Aboriginal Business then the Claims Service Provider:

(i) warrants that it is and will continue to be an Aboriginal Business for the entire Term. It is a condition of this Contract that the Claims Service Provider continues to be an Aboriginal Business;

(ii) must notify icare within 5 Business Days if there is any change in the Claims Service Provider's status as an Aboriginal Business; and

(iii) acknowledges that it will be considered a material breach of this Contract if the Claims Service Provider ceases to be an Aboriginal Business.

26. Performance Guarantee

If item 13 of the Contract Details states that this clause 26 applies, prior to the Commencement Date (or later date if Approved by icare), the Claims Service Provider must provide a Performance Guarantee duly executed by the Guarantor. icare will only release the Guarantor in accordance with the express terms of the Performance Guarantee.

27. Financial Security

27.1 Claims Service Provider must provide and maintain a Financial Security

If item 14 of the Contract Details states that this clause 27 applies, the Claims Service Provider must provide and maintain the Financial Security, in accordance with this clause 27.

27.2 Amount of Financial Security to be provided by the Claims Service Provider

Prior to the Commencement Date (or later date if Approved by icare), the Claims Service Provider must provide an original, duly executed Financial Security for at least the amount set out in item 14 of the Contract Details.

27.3 Basis on which Financial Security held and callable

(a) icare will hold the Financial Security as security for the due and proper performance and completion of the obligations of the Claims Service Provider under the Contract.

(b) If the Claims Service Provider breaches any of its obligations under this Contract (whether by action or omission), in addition to icare's other rights under this Contract or under applicable Law, icare may make demand on the Financial Security and apply the proceeds thereof in satisfaction of any cost, expense, liability, loss or damage incurred or suffered directly or indirectly by icare.

27.4 Inadequacy of Financial Security

If the Financial Security is not sufficient to meet payment of any cost, expense, liability, loss or damage incurred or suffered directly or indirectly by icare in connection with any breach by the Claims Service Provider of its obligations under this Contract (whether by action or omission), the Claims Service Provider shall, within three Business Days of demand, indemnify icare for such amounts.

27.5 Type of Financial Security requirements

(a) Unless otherwise Approved, the Financial Security must:

(i) be issued by a reputable bank, independent insurance company or other financial institution, located in Australia, acceptable to icare;

(ii) be a first demand, irrevocable, unconditional and absolute payment undertaking of the issuer thereof;

(iii) be payable:

(A) on written demand on sight or by post at any office of the issuer in Australia; and

(B) without proof or evidence of entitlement or loss;

(iv) remain in full force and effect until the date when:

(A) icare is satisfied that the Claims Service Provider has fully performed and discharged all of its obligations under this Contract; and

(B) icare has given Approval in accordance with clause 27.10(b) that in its reasonable opinion:

(I) there is no prospect that money or damages will become owing (whether actually or contingently) by the Claims Service Provider to icare; and

(II) no payment by the Claims Service Provider or the provider of the Financial Security is likely to be void, voidable or refundable under Law, including any Law relating to insolvency,

("**Financial Security Expiry Date**"). If the Financial Security is at any time due to expire prior to the Financial Security Expiry Date, the Claims Service Provider must cause a valid renewal, amendment or replacement of the Financial Security satisfying the requirements of this Contract (including this clause 27) to be issued no later than 30 days prior to the current expiration date of the Financial Security. Upon receipt of a valid renewed, amended or replaced Financial Security, icare will promptly return to the Claims Service Provider any original of the then existing Financial Security which such renewed, amended or replaced Financial Security is replacing; and

(v) be freely transferable to any assignee or transferee without any fees or costs charged to icare or any such assignee or transferee.

(b) If at any time:

(i) the issuer of the Financial Security:

(A) fails to make a payment in accordance with a demand made under such Financial Security;

(B) is Insolvent or subject to any insolvency proceedings; or

(C) has a credit rating below:

(I) 'AA minus' with S&P;

(II) 'Aa3' with Moody's; or

(III) the higher of (I) and (II), if the issuer of the Financial Security has credit ratings with both those agencies; or

(ii) any Financial Security delivered to icare ceases to constitute the legal, valid and binding obligations of the issuer thereof enforceable in accordance with its terms, or amounts payable under any Financial Security cease to be freely available for drawing,

the Claims Service Provider shall immediately notify icare upon becoming aware of such circumstance, and in any event within five Business Days of a demand from icare or, if earlier, the date on which the Claims Service Provider becomes aware of the occurrence of such event or circumstance, provide icare with a replacement Financial Security issued by an issuer that meets the requirements of, and is in accordance with the provisions of, this clause 27, in which event, upon receipt of such replacement Financial Security, icare will promptly return the existing Financial Security to the Claims Service Provider.

27.6 No liability for exercise of Financial Security in good faith

icare will have no liability to the Claims Service Provider (whether in negligence or otherwise) for any loss or damage suffered or incurred by the Claims Service Provider where icare exercises its rights under this clause 27 in good faith.

27.7 No action against exercise of Financial Security

The Claims Service Provider must not take any action to injunct or otherwise prevent icare from making a claim or receiving a payment under the Financial Security. This clause 27.7 does not prevent the Claims Service Provider from subsequently taking action to recover from icare, any amount invalidly received by icare under the Financial Security.

27.8 Reinstatement of Financial Security

If icare deducts moneys from the Financial Security and the Contract has not been terminated by icare, then the Claims Service Provider must reinstate the Financial Security to the full amount required, pursuant to clause 27.2, within 20 Business Days.

27.9 Withholding of payment if no reinstatement

icare may withhold payment of any of the fee or amount determined in accordance with clauses 13.1 and 13.2, if the Claims Service Provider has not complied with clause 27.8.

27.10 Release of Financial Security

icare must release the Financial Security if:

(a) icare is satisfied that the Claims Service Provider has fully performed and discharged all of its obligations under this Contract; and

(b) twelve months after the expiration or termination of this Contract has passed, icare has given Approval that in its reasonable opinion:

(i) there is no prospect that money or damages will become owing (whether actually or contingently) by the Claims Service Provider to icare; and

(ii) no payment by the Claims Service Provider or the provider of the Financial Security is likely to be void, voidable or refundable under Law, including any Law relating to insolvency.

27.11 Costs of Financial Security to be provided by the Claims Service Provider

The Claims Service Provider must meet all costs associated with obtaining, maintaining, issuing and renewing the Financial Security.

27.12 Contract Dispute

If icare makes a deduction from the Financial Security, then either party may, within ten Business Days of the deduction, raise a Contract Dispute, and the parties will follow the process for Contract Disputes, set out in clause 57.

SECTION H - Third Party Service Providers, subcontracting and personnel

28. Third Party Service Providers

28.1 Worker's right to appoint a Third Party Service Provider unaffected

Where a Worker has the right at Law or consistently with an icare Policy to appoint a Third Party Service Provider, nothing in this Contract will hinder, vary or reduce this right.

28.2 Panel or icare directed use of Third Party Service Providers

(a) icare may appoint Third Party Service Providers from time to time on an individual basis or to a Panel of one or more types of Third Party Service Providers, as further described in this clause 28.2.

(b) Subject to clause 28.1, if icare:

(i) has established a Panel of one or more types of Third Party Service Providers; or

(ii) otherwise directs the Claims Service Provider to engage a certain Third Party Service Provider or type of Third Party Service Provider,

then the Claims Service Provider must only engage as a Third Party Service Provider a Panellist or other Third Party Service Provider(s) directed by icare, unless otherwise instructed or expressly permitted by icare.

(c) When the Claims Service Provider engages a Panellist under clause 28.2(b), the Claims Service Provider must comply with the terms of the applicable Panel engagement agreement.

(d) When the Claims Service Provider engages a Third Party Service Provider under clause 28.2(b) (whether that Third Party Service Provider is a Panellist or is otherwise a Third Party Service Provider(s) directed by icare):

(i) the Claims Service Provider:

(A) must only engage a Third Party Service Provider of that type or from that Panel; and

(B) is not required to comply with the procurement process in clause 28.4 when acquiring services; and

(ii) icare may direct the Claims Service Provider as to how services are to be acquired from the Third Party Service Provider.

(e) If icare directs the Claims Service Provider to engage a Third Party Service Provider which is not appointed to a Panel, icare may specify the manner and the times in which that Third Party Service Provider is to cease providing services to the Claims Service Provider.

28.3 Where there is no Panel or icare has not directed use of certain Third Party Service Provider(s)

Subject to clause 28.1:

(a) if the Claims Service Provider is not required to engage a Panellist as a Third Party Service Provider or otherwise directed by icare to engage a certain Third Party Service Provider or type of Third Party Service Provider; and

(b) any of the circumstances in the "Third Party Service Provider selection" section of the table at section 1.8 of Schedule 1 ("Customer Engagement & Claims Management Services") applies,

then the Claims Service Provider may acquire the services of a Third Party Service Provider of the Claims Service Provider's own choosing, provided that the Claims Service Provider complies with clauses 28.4 to 28.9.

28.4 Procurement Process

Subject to clause 28.2(d), and unless otherwise agreed by icare:

(a) the Claims Service Provider must comply with NSW government procurement Law or rules as if the Claims Service Provider is a NSW Government Agency, regardless of whether such Law or rules would apply to the Claims Service Provider in the absence of this Contract;

(b) without limiting clause 28.4(a), the Claims Service Provider must:

(i) use fair, transparent and commercially sound decision making, and obtain best value for money, where goods and services are valued up to the

threshold set out in the Enforceable Procurement Provisions, which at the Commencement Date is $680,000 ("**EPP Threshold**") in Third Party SP Payments intended to be procured; and

(ii) conduct an open competitive tender process where:

(A) the procured goods and services are valued over the EPP Threshold in Third Party SP Payments; or

(B) the Claims Service Provider intends to engage a Related Body Corporate of the Claims Service Provider or a Key Input Provider; and

(iii) obtain icare's consent prior to commencing the open tender process contemplated in this clause;

(c) the Claims Service Provider must ensure that the open tender process required by clause 28.4(b):

(i) is competitive;

(ii) is fair and transparent;

(iii) obtains best value for money; and

(iv) ensures probity is maintained in all procurement activities;

(d) the Claims Service Provider must promptly notify icare, and include with such notice, details of the Third Party Service Providers that have been engaged as a result of any procurement process under this clause 28.4; and

(e) the Claims Service Provider must promptly on engagement of a Third Party Service Provider engaged by the Claims Service Provider acting as agent of icare following any open tender process, provide to icare evidence of the qualifications, competencies, permits and training completed by that Third Party Service Provider.

28.5 Prescribed fee and fee must be reasonable if not prescribed

In respect of any Third Party Service Provider (which for clarity, includes a Third Party Service Provider appointed by a Worker):

(a) the Claims Service Provider must not pay more than the fee prescribed by Law or by Regulatory Guidance or otherwise specified by icare for the particular service acquired from a Third Party Service Provider; and

(b) where there is no fee prescribed or otherwise specified for a service acquired from a Third Party Service Provider, the Claims Service Provider may determine the fee that is payable by icare for that service, provided that such fee must be reasonable in all the circumstances and consistent with the requirements of Schedule 1 ("Customer Engagement & Claims Management Services").

28.6 Arrangements with Third Party Service Providers by Claims Service Provider

(a) Except in respect of a Third Party Service Provider engaged under an existing Panel engagement agreement, the Claims Service Provider must, unless otherwise instructed or permitted by icare, ensure that any arrangement that is entered into by the Claims Service Provider with a Third Party Service Provider:

(i) is entered into by the Claims Service Provider acting on behalf of icare, so that an agreement is formed between the Claims Service Provider as agent of icare and the Third Party Service Provider;

(ii) is for a period which does not exceed the Term; and

(iii) includes terms and conditions that:

(A) provide that the Claims Service Provider acts on behalf of icare, so that an agreement is formed between icare and the Third Party Service Provider, including in the case of Third Party Service Providers which provide legal services terms and conditions provide that such Third Party Service Providers owe contractual and professional obligations to icare and not the Claims Service Provider;

(B) require the Third Party Service Provider to assign, transfer or novate the agreement to icare in its own right or its nominee on the same terms and conditions promptly upon notice being given to the Third Party Service Provider;

(C) require the Third Party Service Provider to execute such documents as are reasonably required by icare for the purposes of clause 28.6(a)(iii)(B);

(D) require the Third Party Service Provider to hold all necessary licences, permits, provider numbers, approvals and qualifications;

(E) ensure that any payments to the Third Party Service Provider are consistent with the Workers Compensation Scheme Principles and the Law;

(F) establish a performance management agreement with the Third Party Service Provider, which must specify:

(I) reasonable levels of performance (as agreed with icare) for the delivery of specified service functions; and

(II) an effective performance assessment method which must be commercially reasonable in terms of reporting requirements and include a process to address and rectify under-performance;

(G) require the Third Party Service Provider to provide reports as requested by icare;

(H) ensure that ownership of all Records vests in and remains with icare;

(I) icare or its nominee has a right of prompt and unhindered access to the Records at reasonable times;

(J) a representative from icare may intervene in any disputes between the Claims Service Provider and the Third Party Service Provider;

(K) require the Third Party Service Provider to comply with the requirements of sections 5.1 (Customer Engagement), 5.2 (Customers Experiencing Vulnerability), 5.4 (Behaviour) and 8 (icare's Confidential Information) of Schedule 1 ("Customer Engagement & Claims Management Services");

(L) require the Third Party Service Provider to provide a written confirmation at least once every Year (and at such other time as directed by icare) stating that the Third Party Service Provider:

(I) has paid or will pay all payroll tax;

(II) has paid all applicable workers compensation and any other applicable insurance; and

(III) has paid all other remuneration,

due and payable in accordance with the Law to its employees and contractors that have provided the services; and

(M) require the Third Party Service Provider not to provide, and require the Claims Service Provider not to accept, gifts, benefits or favours, that may relate or may reasonably be perceived as relating to the Third Party Service Provider's delivery of services or the Claims Service Provider's engagement of the Third Party Service Provider, unless Approved by icare.

(b) The Claims Service Provider must not provide or agree to provide any commitment to any Third Party Service Provider in relation to any of the following matters:

(i) volume of service;

(ii) exclusivity;

(iii) payment terms of less than 15 Business Days from receipt of a Tax Invoice; or

(iv) provisions which could create an entitlement of a Third Party Service Provider to compensation or damages as a result of any direction issued by icare to the Third Party Service Provider.

28.7 Management of Third Party Service Providers by Claims Service Provider

(a) Unless required otherwise by icare, the Claims Service Provider is responsible for managing the performance of a Third Party Service Provider (which for clarity,

includes a Third Party Service Provider appointed by a Worker), and in managing the performance must:

(i) comply with section 1.8 (Utilisation and management of Third Party Service Providers) of Schedule 1 ("Customer Engagement & Claims Management Services");

(ii) monitor, evaluate and manage the services and outcomes delivered on Claims by a Third Party Service Provider, including in relation to quality, cost, effectiveness, alignment with and demonstration of activities that are consistent with the Workers Compensation Scheme Principles;

(iii) provide icare with reports in relation to the services and outcomes delivered on Claims by Third Party Service Providers, as requested by icare from time to time;

(iv) ensure the Third Party Service Provider holds all necessary licences, permits, provider numbers, approvals and qualifications; and

(v) diligently manage the Third Party Service Provider's compliance with the requirements of sections 5.1 (Customer Engagement), 5.2 (Customers Experiencing Vulnerability), 5.4 (Behaviour) and 8 (icare's Confidential Information) of Schedule 1 ("Customer Engagement & Claims Management Services").

(b) The Claims Service Provider must, unless otherwise required by icare, promptly and fully:

(i) enforce icare's rights (unless a breach is minor and has no significant impact on the delivery of the Services to icare); and

(ii) meet all of its and icare's obligations,

under any agreements with Third Party Service Providers that are Panellists or otherwise engaged by the Claims Service Provider acting as agent of icare.

28.8 Restrictions on engagement of Third Party Service Providers

Unless otherwise Approved by icare, the Claims Service Provider:

(a) must not engage a Subcontractor of the Claims Service Provider or each of their Related Bodies Corporate as a Third Party Service Provider;

(b) must not obtain legal services in relation to the Scheme, except as permitted in accordance with any requirements relevant to legal services set out in Schedule 1 ("Customer Engagement & Claims Management Services"); and

(c) may only appoint a Third Party Service Provider to collect debts or amounts outstanding where the debt or amount outstanding has remained uncollected for a period of at least 30 Calendar Days;

(d) must not enter into an agreement (either itself or as agent for icare) with a Third Party Service Provider for services to be provided in connection with the Scheme

where those services are within a Third Party Service Provider category for which icare has established a Panel; and

(e) must not acquire services to be provided in connection with the Scheme that are in the nature of services provided by Third Party Service Providers from a third party that is not appropriately accredited (in compliance with Law and regulatory requirements) or otherwise approved by SIRA.

28.9 Removal

Without limiting clause 28.2, icare may instruct the Claims Service Provider:

(a) to engage or not engage a particular Third Party Service Provider in a specific case; or

(b) not to engage a Third Party Service Provider from icare's Panel for the purposes of providing services under the Contract.

29. Subcontracting

29.1 Subcontracting permitted

The Claims Service Provider may engage third parties to fulfil the Claims Service Provider's obligations to perform the Services, subject to the terms of this clause 29 and clause 30.

29.2 Claims Service Provider not relieved of obligations by subcontract

The Claims Service Provider:

(a) is fully responsible for the performance of the Services even if the Claims Service Provider subcontracts any aspect of the provision of the Services and will be liable to icare for the acts and omissions of any Subcontractors as if they were the acts or omissions of the Claims Service Provider;

(b) must ensure that any Subcontractors are qualified and competent to perform their responsibilities; and

(c) agrees that:

(i) it, and not icare, will be the sole point of contact for all Subcontractors, including in regard to payment; and

(ii) icare will not be under any obligation to make payment for any monies due by the Claims Service Provider to any Subcontractor.

29.3 Requirements of Subcontracts

The Claims Service Provider must ensure that each subcontract entered into with a Subcontractor:

(a) contains clauses requiring the Subcontractor, on receipt of a direction from icare, to immediately:

(i) execute such Documents and do such things as are required by icare for the purposes of this clause 29.3; and

(ii) return any Documents, assets and property owned by icare to the Claims Service Provider or icare or its nominee; and

(b) includes an obligation to comply with applicable Laws and Regulatory Guidance.

30. Key Input Providers

30.1 Approval of Key Input Providers

The Claims Service Provider must not engage a Key Input Provider except with the prior Approval of icare, which will not be unreasonably withheld.

30.2 Information as to Key Input Providers

(a) The Claims Service Provider must provide to icare detail on any proposed Key Input Provider, including:

(i) the Key Input Provider's:

(A) name, address, and ABN;

(B) scope of work to be performed;

(C) identity of its directors and key Personnel; and

(D) qualifications to perform the work;

(ii) the proposed contract between the Claims Service Provider and the Key Input Provider; and

(iii) any other information reasonably requested by icare.

(b) Without limiting clause 30.2(a), icare may (only to the extent related to the provision of the Services) impose terms and conditions on the Approval of any Key Input Provider, including requiring that the Key Input Provider execute an agreement on reasonable terms satisfactory to icare which, among other things, will include an acknowledgement and agreement by the Key Input Provider that:

(i) to the extent that it performs any duty or obligation of the Claims Service Provider (including any Services), it owes the same duties and obligations to icare as owed by the Claims Service Provider and it will comply with the terms and conditions of this Contract as if it was the Claims Service Provider; and

(ii) it has no entitlement to any Remuneration under this Contract or otherwise from icare and its sole entitlement for any consideration for the provision of Services or any obligations under this Contract on behalf of the Claims Service Provider by it is as against the Claims Service Provider and that consideration is not recoverable from icare.

(c) If the Key Input Provider is Approved by icare, the Claims Service Provider agrees that:

(i) any direction given or other requirement notified to the Key Input Provider by icare will be taken to be a direction given or other requirement notified to the Claims Service Provider; and

(ii) the Claims Service Provider and the Key Input Provider will not vary the terms and conditions of any Approved agreement between the Claims Service Provider and the Key Input Provider without the prior Approval of icare except to the extent that the variation to the terms and conditions is not related to, or otherwise affects, the Services or the Claims Service Provider's duties or obligations under this Contract;

(iii) where the Key Input Provider is used to perform part of the Services, then the Claims Service Provider must procure that, at the time of submission of each invoice to the Claims Service Provider, the Key Input Provider must confirm in writing that the Key Input Provider has met all its obligations to the Key Input Provider's employees and contractors to pay all:

(A) payroll tax;

(B) applicable workers compensation insurance; and

(C) remuneration,

and has otherwise complied with Law in respect of those employees and contractors.

30.3 Key Input Provider Register

(a) The Claims Service Provider must record details of each Key Input Provider in the Key Input Provider Register.

(b) The Claims Service Provider must:

(i) provide the initial version of the Key Input Provider Register at the Commencement Date; and

(ii) ensure that:

(A) the Key Input Provider Register is kept up-to-date and includes all relevant details for each Key Input Provider whether current or expired; and

(B) an updated Key Input Provider Register is provided to icare on or prior to 1 November in each Year or such other date specified by icare.

31. Personnel

31.1 Claims Service Provider responsible for Personnel

The Claims Service Provider is responsible for all the planning, scheduling, supervision, training, and safety of its Personnel that are engaged in providing the Services.

31.2 Compliance with professional standards

The Claims Service Provider will:

(a) ensure that all of the Personnel involved in the provision of the Services, or having specified roles in relation to this Contract:

(i) are of good character and repute and are fit and proper;

(ii) have the necessary training, experience and qualifications to fulfil their appointed roles; and

(iii) maintain their skills by completing continuing professional development activities,

with reference to applicable prudential standards, professional standards and codes of conduct as set out in the provisions of Schedule 1 ("Customer Engagement & Claims Management Services"); and

(b) promptly disclose any matters which come to its attention with respect to a breach or potential breach of this clause 31.2.

31.3 Removal of Personnel

If icare reasonably requires the removal of Personnel of:

(a) the Claims Service Provider;

(b) any Service Company; or

(c) any Key Input Provider,

from the provision of Services, the Claims Service Provider must immediately (unless otherwise required by icare), remove or procure the removal of that individual from the provision of the Services.

31.4 Re-instatement only with icare Approval

If an individual has been removed at the request of icare under clause 31.3, such individual can only return to the provision of Services with Approval of the icare Authorised Representative.

31.5 No Obligation to Give Reasons or Compensation

icare is not required to give any reasons, nor is it required to pay any compensation for acting consistently with clauses 31.3 or 31.4.

32. Key Personnel

32.1 Requirements for Key Personnel

The Claims Service Provider's Key Personnel must:

(a) be Approved by icare, with such Approval not to be unreasonably withheld;

(b) have completed a police/criminal history check prior to commencing work in respect of the Services, written confirmation of which must be provided to icare within 3 Business Days of a request being made. The Claims Service Provider must ensure, and if required by icare must substantiate, that each Key Personnel: (i) consents to the collection by icare of the information in that check for the purposes of administering the Scheme; and (ii) is fit and proper for the role assigned, having regard to the outcome of the police/criminal history check; and

(c) be available to attend, or participate in, meetings at a location, or by such technological means, as reasonably required by icare from time to time.

32.2 Evidence of qualifications

Within five Business Days of receipt of a request from icare, the Claims Service Provider must provide to the icare Authorised Representative evidence of the qualifications, experience (including tenure with the Claims Service Provider), competencies and permits held, and training completed, by any of the Key Personnel providing the Services.

32.3 No unreasonable diversion of Key Personnel

The Claims Service Provider must ensure that, unless otherwise agreed with icare, its Key Personnel are dedicated exclusively, or for such other proportion of their time as agreed with icare, to providing services to icare under Claims Management Agreements.

32.4 Absence of Key Personnel

(a) The Claims Service Provider must obtain the prior Approval of icare (not to be unreasonably withheld) if any of its Key Personnel will be absent from providing the Services for longer than 15 consecutive Business Days.

(b) Where any of the Claims Service Provider's Key Personnel are absent from providing the Services for more than ten consecutive Business Days then the Claims Service Provider must, at its own cost, provide a replacement (who is substantively of equivalent or more senior status than the absent Key Personnel) that is acceptable to icare.

32.5 Replacement Key Personnel

(a) The Claims Service Provider must not remove or replace any of its Key Personnel without icare's prior Approval unless:

(i) required by Law or Regulatory Guidance;

(ii) the relevant Key Personnel has resigned, is injured, is permanently disabled or subject to maternity or paternity leave;

(iii) there is evidence which the Claims Service Provider certifies that it believes is sufficient at Law to demonstrate gross misbehaviour of the Key Personnel;

(iv) the Claims Service Provider certifies that it has proper grounds to terminate the contract of employment of the Key Personnel; or

(v) the Claims Service Provider has notified icare of a suitable replacement for the Key Personnel (such notice to be given at least ten Business Days prior to the proposed replacement) and icare has Approved the replacement. icare will not refuse Approval unreasonably, except during the Disengagement Period, when clause 60.4 will prevail.

(b) If icare requests, the Claims Service Provider must provide icare with such information as icare reasonably requires concerning any proposed replacement of any Key Personnel.

SECTION I - Intellectual property, privacy and confidentiality

33. Intellectual Property Rights

33.1 Ownership of Records and Foreground Material

(a) The parties acknowledge and agree that:

(i) the Records;

(ii) the Foreground Material; and

(iii) all Intellectual Property Rights in the Records and the Foreground Material,

are the property of icare, and will, on creation, vest in icare.

(b) Subject to clause 33.2(b), the Claims Service Provider assigns, and must ensure that its Personnel assign, to icare, on the later of the Commencement Date and creation, all rights, title and interest (including all Intellectual Property Rights) which any of them have in Foreground Material and Records and must do all things necessary to give effect to clause 33.1(a), including executing and delivering documents as required.

33.2 Claims Service Provider licence to icare

(a) Subject to clause 33.2(b), the Claims Service Provider grants to, or must obtain for icare and any nominee of icare (including any other person who exercises any of the functions of icare or provides services to icare), an irrevocable, world-wide, royalty-free and licence fee-free, non-exclusive licence (including the right to sublicense) to use, reproduce, adapt, modify and communicate the Licensed Claims Service Provider Material for the Term in order to:

(i) fully utilise and exploit the Deliverables; and

(ii) otherwise receive the full benefit of its rights under this Contract (including the receipt and use of the Services and Deliverables).

To the extent that Licensed Claims Service Provider Material is incorporated in any Deliverable (including Foreground Material) that icare is entitled to retain after the Term, the aforementioned licence will be perpetual.

(b) The Claims Service Provider agrees that it will not incorporate any third party Intellectual Property Rights into a Deliverable or other Material which icare needs to use in order to fully utilise and exploit the Deliverables or receive and use the Services, unless:

(i) it first obtains a licence for icare to use such third party Intellectual Property Rights that is consistent with the licence granted under clause 33.2(a); or

(ii) where it is unable to obtain the licence under clause 33.2(b)(i), it first notifies icare of the terms of the licence under which the Claims Service Provider is provided and entitled to sub-license the third party Intellectual Property Rights, in which event, icare may either:

(A) Approve the incorporation of such third party Intellectual Property Rights based on the terms of the licence as notified under clause 33.2(b)(ii); or

(B) not Approve the incorporation of such third party Intellectual Property Rights based on the terms of the licence as notified under clause 33.2(b)(ii), in which case the Claims Service Provider must not include such third party Intellectual Property Rights in its Deliverables or other Material which icare needs to use in order to fully utilise and exploit the Deliverables or receive and use the Services.

(c) Except as specifically provided in this Contract, nothing in this Contract transfers to icare any ownership rights in the Claims Service Provider Material.

33.3 Ownership of icare Material

Except as stated otherwise in this Contract, nothing in this Contract affects the ownership of icare Material (and Intellectual Property Rights in icare Material).

33.4 Intellectual Property Rights licences to Claims Service Provider

To the extent that the Claims Service Provider needs to use any icare Material for the purpose of performing its obligations under this Contract, icare grants to the Claims Service Provider, subject to any reasonable requirement notified by icare and the terms of this Contract, a world-wide, royalty-free and licence fee-free, non-exclusive, non-transferable licence (including the right to sublicense) for the Term to use, copy, modify and, subject to the Claims Service Provider complying with clauses 34 (Confidentiality) and 37 (Protection

of Personal Information), communicate icare Material solely for the purpose of performing its obligations under this Contract.

33.5 Trade marks

(a) From the Commencement Date, the Claims Service Provider may use the icare Logos for the Term and for such further period as icare may Approve, solely for the purposes of communications on icare's behalf in performing the Services.

(b) In its use of the icare Logos, the Claims Service Provider must comply with icare's brand guidelines as notified by icare to the Claims Service Provider and any other requirements of icare notified from time to time.

33.6 Approval of format of Documents

The Claims Service Provider must seek individual Approval of icare for the format of any letterhead, cheques, forms and standard Documentation used in relation to the Services, unless the format is described in the Manuals or icare Operational Materials.

34. Confidentiality

34.1 Duty of confidentiality

Each party must:

(a) hold the other party's Confidential Information in strict confidence;

(b) not allow any persons to have unauthorised access to the other party's Confidential Information; and

(c) not disclose any of the other party's Confidential Information to any person, except:

(i) in accordance with this clause 34; or

(ii) after receiving the written consent or Approval of the other party.

34.2 Use of icare's Confidential Information

(a) The Claims Service Provider must not make any use of icare's Confidential Information or any part of it, except for performing its obligations or exercising its rights under this Contract.

(b) Subject to clause 34.5, prior to disclosing any of icare's Confidential Information to any third party, including a Subcontractor or its Personnel, the Claims Service Provider must provide notice to icare and obtain its Approval for the disclosure and use of the Confidential Information, which may be denied or granted at icare's discretion and subject to any conditions that icare thinks fit (and which Approval may, in the case of disclosure of icare's Confidential Information to Claims Service Provider Personnel providing Services from a location outside Australia, be obtained under an Approved Offshore Location Approval).

34.3 Obligations on disclosure

(a) Prior to disclosure of icare's Confidential Information (except where the disclosure is made in accordance with clause 34.4(a) or where clause 34.5 applies), the Claims Service Provider must require the party to which the Confidential Information is to be disclosed, to sign and execute the Confidentiality Deed.

(b) The Claims Service Provider must ensure that any person to whom it is authorised to disclose icare's Confidential Information:

(i) is aware of, and ensures that its employees and professional advisers, are aware of, the confidential nature of icare's Confidential Information; and

(ii) holds icare's Confidential Information in confidence, on no less onerous terms than those set out in this Contract.

34.4 Permitted disclosure

A party is permitted to disclose the other's Confidential Information in the following circumstances:

(a) a party may disclose Confidential Information to its legal, financial or other professional advisers, and only to the extent reasonably necessary, for the sole purpose of seeking advice from such advisors;

(b) icare may disclose any information provided by the Claims Service Provider to:

(i) any relevant authority within the meaning of section 10 of the *State Insurance and Care Governance Act 2015* (NSW);

(ii) SIRA (in its role as regulator), and its personnel; or

(iii) any other Government Agency, and its personnel,

provided that if the information is Confidential Information, icare must take all reasonable steps to ensure that such information is treated as confidential by SIRA, the relevant authority (as defined in section 10 of the *State Insurance and Care Governance Act 2015* (NSW)), and other such Government Agencies;

(c) icare may disclose the Claims Service Provider's Confidential Information:

(i) to any Minister, Parliamentary Committee or Parliament; and

(ii) to any Government Agency, to carry out any of its functions, powers or discretions;

(d) a party may disclose any Confidential Information to an auditor for the purposes or conducting an audit, inspection or test, in accordance with clause 46; and

(e) where required or permitted by Law or Regulatory Guidance.

34.5 Disclosures relating to Claims

The Claims Service Provider may disclose icare's Confidential Information relating to Claims to Workers, Employers or Third Party Service Providers, only to the extent

necessary to ensure the efficient provision of the Services and subject always to any privacy or statutory secrecy obligation owed by the Claims Service Provider. Such disclosure does not require the Claims Service Provider to obtain an executed Confidentiality Deed from the Worker, Employer or Third Party Service Provider (as applicable).

34.6 Information about Performance Measures not confidential

The Claims Service Provider acknowledges and agrees that:

(a) information about the degree to which the Claims Service Provider has achieved the Performance Measures when managing Claims under this Contract is not Confidential Information of the Claims Service Provider;

(b) icare may, from time to time, choose to issue to third parties (including Other Claims Service Providers, SIRA, Employers and the public), reports consisting of Records, and any other information, including details of case loads and tenure of Personnel and comparative performance data relating to (and identifying) the Claims Service Provider when icare, acting reasonably, considers that publication of such reports is likely to promote the Workers Compensation Scheme Principles. However, icare agrees that such publication will not include Personal Information other than in compliance with applicable privacy laws including the State Privacy Laws; and

(c) icare has no liability to the Claims Service Provider in connection with any inaccuracies in comparative performance data that icare issues or publishes. If reasonably practicable, icare will give the Claims Service Provider:

(i) for any issuance or publication of comparative performance data in the first four months of issuance or publication, 10 Business Days; and

(ii) for all subsequent issuances or publications of comparative performance data, 3 Business Days,

to review the comparative performance data insofar as it relates to the Claims Service Provider for its accuracy before it is issued or published. If the Claims Service Provider identifies any errors in the data, it may notify icare and icare will use reasonable endeavours to correct any agreed error promptly following the Claims Service Provider's notification.

35. Public Access to Government Information

35.1 Government Contracts Register

The Claims Service Provider acknowledges that icare may be obliged under Pt. 3, Div. 5 of the *Government Information (Public Access) Act 2009* (NSW) (**GIPA Act**), at any time during or after the Term, to publish this Contract and/or information relating to this Contract and services provided pursuant to this Contract on icare's contracts register and on any website as required by the GIPA Act. The commercial in confidence provisions of this Contract are specified in item 16 of the Contract Details.

35.2 Right of access (GIPA Act section 121)

(a) Upon written request from icare, the Claims Service Provider must provide icare with an immediate, unhindered and independent right of access to the information as set out in section 121 of the GIPA Act. The Claims Service Provider will endeavour to ensure that the requested information is provided to icare within five Business Days.

(b) The Claims Service Provider will provide copies of any of the information set out in section 121 of the GIPA Act, as requested by icare, at the Claims Service Provider's own expense.

35.3 Consultation Clause (GIPA Act section 54)

Where required by the GIPA Act, icare will take reasonably practicable steps to consult with the Claims Service Provider in accordance with that section before providing any person with access to information relating to the Claims Service Provider pursuant to the GIPA Act.

35.4 Access to information

(a) The Claims Service Provider must notify icare immediately of any request received from any person which relates to or arises out of the GIPA Act, and forward such request to icare gipa@icare.nsw.gov.au (or other email address notified by icare to the Claims Service Provider from time to time) for processing by icare in accordance with the applicable provisions of the GIPA Act.

(b) The Claims Service Provider is required to provide reasonable assistance and guidance in complying with the GIPA Act relating to the Services provided under this Contract.

(c) The Claims Service Provider is to process any informal requests for information relating to the Services provided under this Contract made by or on behalf of a claimant in accordance with any icare Policies notified by icare to the Claims Service Provider in writing.

36. Media and Public Relations

36.1 No media statements without Approval

The Claims Service Provider must not, and must ensure that its Personnel do not, make any statement to media or the public on behalf of icare or with respect to the Services, or the Scheme (including Workers Compensation Scheme Principles or icare's policies) without first obtaining Approval.

36.2 Media enquiries to be referred

All enquiries from the media arising out of or in connection with this Contract, including Remuneration, payments of Benefits, payments to Third Party Service Providers, the Services, icare, SIRA, any relationships involving icare, the Claims Service Provider or any Other Claims Service Providers, WH&S and Workers Compensation Legislation and

proposed amendments to such Laws, must be immediately referred to the icare Authorised Representative without comment to the media.

36.3 Requirement to notify

The Claims Service Provider must immediately notify the icare Authorised Representative of all events that arise in the course of providing the Services that have or are likely to receive media attention or public attention.

36.4 Requirements regarding marketing material

icare may require the Claims Service Provider to immediately withdraw any marketing material that relates to the Scheme that has been made public by the Claims Service Provider without any liability, and at no cost, to icare.

36.5 Comparative Material

The Claims Service Provider must not publish or disclose any information to any third party which compares the Claims Service Provider's performance to any Other Claims Service Provider's performance or to the Workers Compensation Scheme Principles without prior Approval, unless such comparative information has already been published into the public domain by icare. For the avoidance of doubt, the identity of any Other Claims Service Providers must not be used in comparative performance publications or disclosures unless that identity has been published in the public domain by icare in the context of that comparative performance information.

36.6 Documents required to be sent by icare

The Claims Service Provider must include any Document that icare requires to be sent to any person:

(a) at no cost to icare if it can be included with any of the Claims Service Provider's planned communications; or

(b) at icare's cost, if the Claims Service Provider has to send it separately.

36.7 Permitted disclosures

Nothing in this clause 36 prevents the Claims Service Provider disclosing information to any person to the extent that either:

(a) the disclosure is required by Law; or

(b) the information is not Confidential Information.

37. Protection of Personal Information

37.1 Compliance with Privacy Laws

(a) The Claims Service Provider must comply with:

(i) all relevant privacy and data protection legislation applicable in NSW, in particular the *Privacy and Personal Information Protection Act 1998* (NSW)

and the *Health Records and Information Privacy Act* 2002 (NSW) (**State Privacy Laws**); and

(ii) cabinet administrative instructions or NSW government standards relating to personal or health information,

in connection with the performance of this Contract as if the Claims Service Provider is a NSW Government Agency, regardless of whether such legislation, instructions and standards would apply to the Claims Service Provider in the absence of this Contract.

(b) In addition to any obligations it has under clause 37.1(a), the Claims Service Provider must in respect of this Contract, and with respect to all of icare's Confidential Information and any other Confidential Information that it obtains in relation to or in connection with the performance of this Contract that comprises Personal Information:

(i) comply with the requirements of Schedule 8 (“Information Security and Management”);

(ii) co-operate with any reasonable Demands or inquiries made by any Authority responsible for administering the State Privacy Laws;

(iii) ensure that any person who has or will be given the ability to access information in respect of which icare has obligations under the State Privacy Laws is made aware of, and undertakes in writing, to observe the relevant provisions of this clause 37.1;

(iv) take all reasonable measures to ensure that such information is protected against loss and against unauthorised access, use, modification, disclosure or other misuse and that only authorised representatives, employees and officers of the Claims Service Provider have access to it; and

(v) in respect of any person who has or will be given the ability to access information in respect of which icare has obligations under the State Privacy Laws:

(A) require that person to complete privacy training at induction and on a periodic basis; and

(B) provide attestations and reports confirming completion of that training in accordance with Schedule 3 (“Performance Management & Governance”); and

(vi) not transfer such information outside NSW, or allow parties outside NSW to have access to it, without the prior approval of icare (and provided the Claims Service Provider complies with all conditions of such approval) or in accordance with an Approved Offshore Location Proposal.

(c) The Claims Service Provider acknowledges that any act or practice in relation to personal information that is not authorised by this Contract is subject to the *Privacy*

Act 1988 (Cth) on the basis that it is not exempted by operation of section 7B(5) of the *Privacy Act 1988* (Cth).

(d) The Claims Service Provider also undertakes to ensure that its Personnel will comply with the obligations specified in clause 37.1.

37.2 Subcontracts

The Claims Service Provider must ensure that any contract it enters with a Subcontractor under this Contract contains provisions to ensure that the Subcontractor has the same awareness and obligations that the Claims Service Provider has under clauses 37.1 and 37.2 including this requirement in relation to subcontracts.

37.3 Confidentiality Deed

The Claims Service Provider must:

(a) if requested by icare in writing, prior to disclosing Personal Information obtain a signed Confidentiality Deed from the intended recipient, and such of the recipient's Personnel or agents, as requested by icare; and

(b) promptly comply with icare's requirements in respect of any action required to enforce such Confidentiality Deed, at the Claims Service Provider's own expense.

Part 5 How we work together to deal with change over the contract

Simplified outline of this Part:

This Part 5 contains:

- Section J – Directions and Change Management; and
- Section K – Governance, reporting and audit.

Section J sets out provisions relating to the management of changes in Law and Directions (including appropriate funding by icare of the Claims Service Provider's costs for addressing material changes in Law or Directions) - see Diagrams 3 and 4 overleaf for summaries of these provisions - as well as other changes to the Contract and ancillary documents.

Section K sets out the framework for governance and reporting under the Contract (including the interaction of key representatives for the parties, meetings and reporting requirements) and audit of the Claims Service Provider's performance (including audit by NSW Auditor General and SIRA).

Simplified outline of this Part:

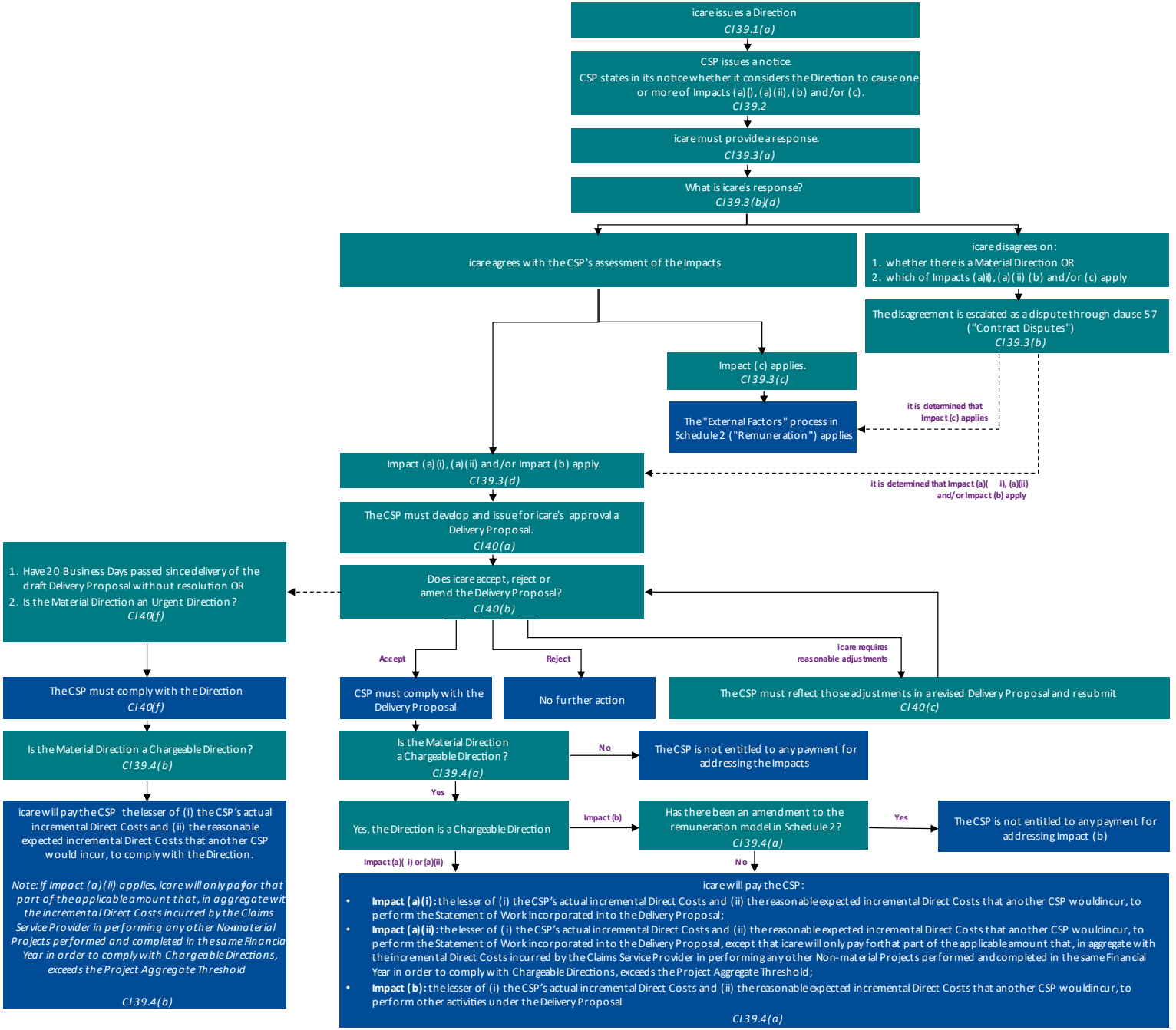
Diagram 3

icare may issue Directions at any time as to the manner in which the CSP is to perform the Services or any other obligation under this Contract. Generally, subject to the process described below (where a Direction is agreed or determined to be a Material Direction requiring a Material Project or a material change to the Services or the manner of performance), the CSP must comply with a Direction in accordance with its stipulated timeframes, or immediately in the case of an Urgent Direction.

What is a "Material Direction"?

A "Material Direction" is a Direction to which any **one or more** of the following impacts will apply:

- **Impact (a)(i):** the CSP must undertake a Material Project in order to comply with the Direction;
- **Impact (a)(ii):** the CSP must undertake a Non-material Project in order to comply with the Direction, where the CSP's incremental Direct Costs of performing that Non-material Project, and any other Non-material Projects performed and completed in the same Financial Year in order to comply with Chargeable Directions exceed the Project Aggregate Threshold ($250,000) in aggregate;
- **Impact (b):** the CSP must make material changes to the Services or the manner of its performance of the Services or its other obligations in the Contract in order to comply with the Direction; or
- **Impact (c):** where the Direction is a Chargeable Direction (only), the CSP's compliance with the Direction will justify a change to the Performance Measures or remuneration model set out in Schedule 2 ("Remuneration").



Simplified outline of this Part:

Diagram 4

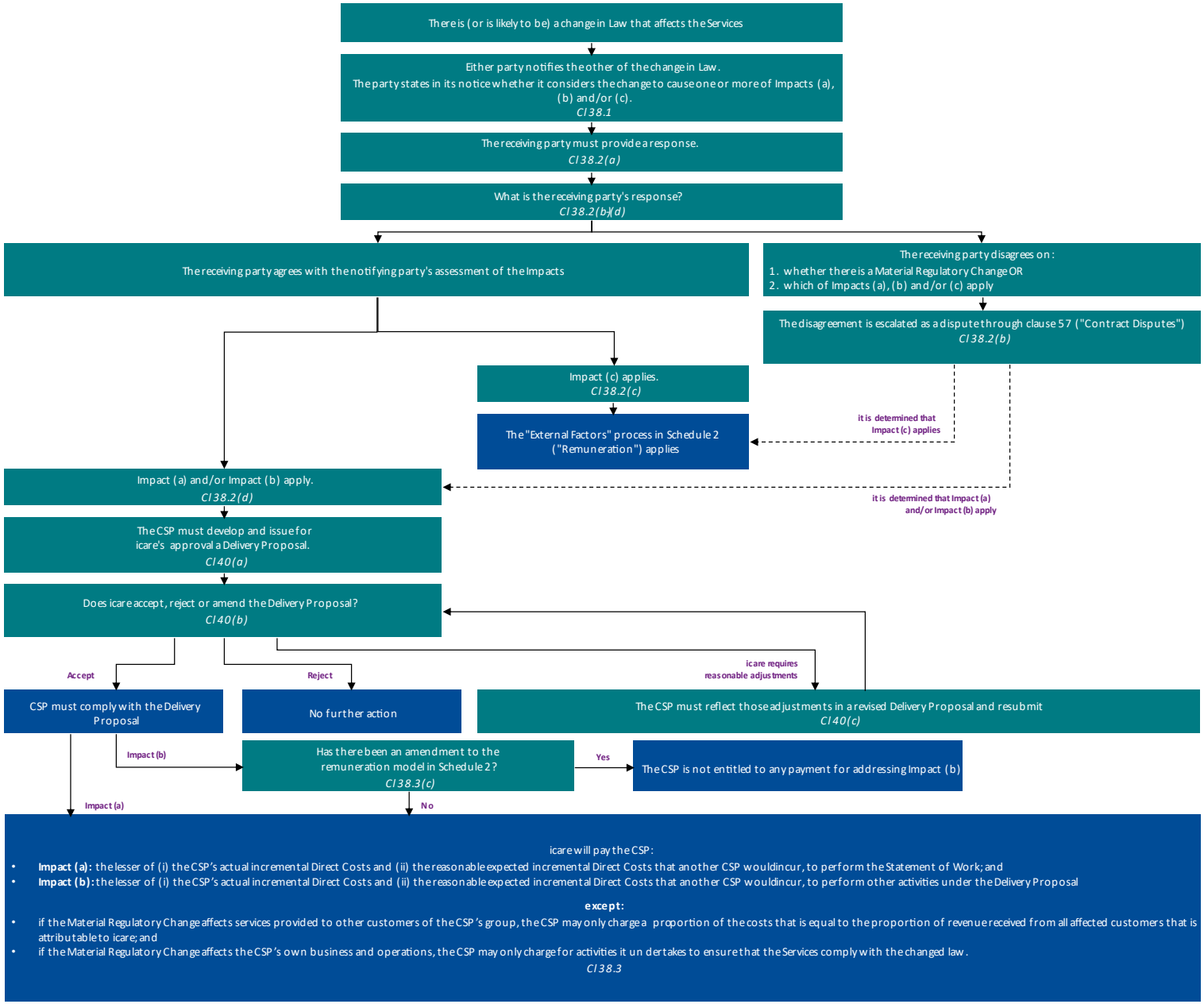
The CSP has general obligations in the Contract to comply with all applicable Laws (without the need for icare to issue Directions).

The process set out below relates to the parties' management and funding of activities required to address Material Regulatory Changes.

What is a "Material Regulatory Change"?

A "Material Regulatory Change" is a change in Law affecting the Services to which any one or more of the following impacts will apply:

- **Impact (a):** the change in Law will require the CSP to undertake a Material Project in order to ensure that its performance of the Services will comply with the Law as changed;
- **Impact (b):** the change in Law will require the CSP to make material changes to the Services or the manner of its performance of the Services in order to comply with the Law as changed; or
- **Impact (c):** the CSP's performance of the Services in compliance with the Law as changed will justify a change to the Performance Measures or remuneration model set out in Schedule 2 ("Remuneration").



SECTION J - Directions and Change Management

38. Changes in Law

38.1 Notification

If a change in applicable Law that affects the Services occurs or is likely to occur, either party may notify the other, and state in its notice whether it considers that any one or more of the following will apply:

(a) the change in Law will require the Claims Service Provider to undertake a Material Project in order to ensure that its performance of the Services will comply with the Law as changed;

(b) the change in Law will require the Claims Service Provider to make material changes to the Services or the manner of its performance of the Services in order to comply with the Law as changed; or

(c) the Claims Service Provider's performance of the Services in compliance with the Law as changed will justify a change to the Performance Measures or remuneration model set out in Schedule 2 ("Remuneration").

A change in Law notified under this clause 38.1 to which one or more of clauses 38.1(a) to 38.1(c) applies is a **Material Regulatory Change**.

38.2 Response

(a) Following receipt of a notice under clause 38.1, the receiving party will promptly (and in any event within five Business Days of receipt) provide a response in writing confirming whether it considers the change in Law to be a Material Regulatory Change, and if so which of clauses 38.1(a) to 38.1(c) applies in respect of that Material Regulatory Change.

(b) If the parties disagree on:

(i) whether the change in Law is a Material Regulatory Change; or

(ii) which of clauses 38.1(a) to 38.1(c) apply in respect of a Material Regulatory Change,

either party may raise a Contract Dispute and the parties will follow the process for Contract Disputes set out in clause 57.

(c) If the parties agree or it is determined that a Material Regulatory Change has occurred or is likely to occur to which clause 38.1(c) applies, then section 11.5 (External Factor Response by icare) of Schedule 2 ("Remuneration") will apply.

(d) If the parties agree or it is determined that a Material Regulatory Change has occurred or is likely to occur to which either or both of clauses 38.1(a) and 38.1(b) apply, then clause 40 ("Delivery Proposals") will apply.

38.3 Entitlement to charge

If a Delivery Proposal is approved by icare under clause 40 in respect of a Material Regulatory Change, then, unless otherwise agreed in the approved Delivery Proposal:

(a) the Claims Service Provider will be entitled to charge icare for its performance of any Statement of Work approved as part of the Delivery Proposal, up to the lesser of:

  (i) the amount icare reasonably believes would be the incremental Direct Costs incurred by an Other Claims Service Provider to perform the Statement of Work, operating at Best Industry Practice; and

  (ii) the actual incremental Direct Costs incurred by the Claims Service Provider to perform the Statement of Work; and

(b) the Claims Service Provider will be entitled to charge icare for its performance of any other activities under the Delivery Proposal up to the lesser of:

  (i) the amount icare reasonably believes would be the incremental Direct Costs incurred by an Other Claims Service Provider to perform those other activities, operating at Best Industry Practice; and

  (ii) the actual incremental Direct Costs incurred by the Claims Service Provider to perform those other activities,

except that:

(c) the Claims Service Provider will not be entitled to any payment under clause 38.3(b) if clause 38.2(c) applies and icare has amended the remuneration model under section 11.5 (External Factor Response by icare) of Schedule 2 ("Remuneration"); and

(d) if the Material Regulatory Change relates to a change in Law that:

  (i) affects the services which the Claims Service Provider Group provides to any of its other customers (with icare, each an **Affected Customer**) or work undertaken under a Statement of Work is applicable to or required in respect of the services provided to such Affected Customer(s) (**Common Work**), then the Claims Service Provider may only charge the proportion of the amounts that would otherwise be chargeable for the Common Work under clauses 38.3(a) and 38.3(b) that is equal to the proportion of revenue received from all Affected Customers that is attributable to icare; or

  (ii) also applies to the Claims Service Provider's own business and operations, then the Claims Service Provider may only charge for any activities that it undertakes to ensure that its performance of the Services complies with the Law as changed. The Claims Service Provider may not charge for any activities that it undertakes to ensure compliance in relation to any services it provides to other customers or in relation to any other part of its business.

39. Directions

39.1 Directions

(a) The icare Authorised Representative or their delegate may issue directions at any time as to the manner in which the Claims Service Provider is to perform the Services or any other obligation under this Contract, including directions:

(i) in relation to:

(A) engagement (or cessation of engagement) of or interaction with Third Party Service Providers, including as further described in clause 28;

(B) compliance with Regulatory Guidance and any other requirements issued or published by SIRA or other regulatory body; and

(C) implementation of remediation programs in response to performance failures or other breaches of the Contract;

(ii) for governance or assurance activity initiated by icare in relation to this Contract; and

(iii) as contemplated in clauses 9.1(f), 12.3, 41.2, 41.4, 46.14 and 55.4(c).

(b) Subject to clause 40, the Claims Service Provider must:

(i) perform the Services (or any other obligations under this Contract) and otherwise comply with any Direction issued or deemed to be issued under clause 39.1(a) in accordance with, and within any reasonable timeframe specified in, the Direction; and

(ii) immediately comply with a Direction which is specified to be an Urgent Direction.

39.2 Notification

Following receipt of a Direction issued or deemed to be issued under clause 39.1(a), the Claims Service Provider will promptly (and in any event within five Business Days of receipt or such other reasonable timeframe as icare may specify in its notice depending on the subject matter of the Direction) provide a notice in writing confirming whether it considers that any one or more of the following will apply:

(a) the Claims Service Provider must undertake:

(i) a Material Project in order to comply with the Direction; or

(ii) a Non-material Project in order to comply with the Direction, where the Claims Service Provider's incremental Direct Costs of performing that Non-material Project and any other Non-material Projects performed and completed in the same Financial Year in order to comply with Chargeable Directions exceed the Project Aggregate Threshold in aggregate;

(b) the Claims Service Provider must make material changes to the Services or the manner of its performance of the Services or its other obligations in the Contract in order to comply with the Direction; or

(c) where the Direction is a Chargeable Direction, the Claims Service Provider's compliance with the Direction will justify a change to the Performance Measures or remuneration model set out in Schedule 2 ("Remuneration").

A Direction issued under clause 39.1(a) to which one or more of clauses 39.2(a) to (c) applies is a **Material Direction**.

39.3 Response

(a) Following receipt of a notice under clause 39.2, icare will promptly (and in any event within five Business Days of receipt or such other reasonable timeframe as icare may specify depending on the subject matter of the Direction) provide a response in writing confirming whether it considers the Direction to be a Material Direction, and if so, which of clauses 39.2(a) to (c) applies in respect of that Material Direction.

(b) If the parties disagree on:

(i) whether the Direction is a Material Direction; or

(ii) which of clauses 39.2(a) to (c) apply in respect of a Material Direction,

either party may raise a Contract Dispute and the parties will follow the process for Contract Disputes set out in clause 57.

(c) If the parties agree or it is determined that clause 39.2(c) applies, then section 11.5 (External Factor Response by icare) of Schedule 2 ("Remuneration") will apply.

(d) If the parties agree or it is determined that icare has issued a Material Direction to which either or both of clauses 39.2(a) and 39.2(b) apply, then clause 40 will apply.

39.4 Entitlement to charge

(a) If a Delivery Proposal is approved by icare under clause 40 in respect of a Material Direction that is a Chargeable Direction, then, unless otherwise agreed in the approved Delivery Proposal:

(i) the Claims Service Provider will be entitled to charge icare for its performance of any Statement of Work approved as part of the Delivery Proposal, up to the lesser of:

(A) the amount icare reasonably believes would be the incremental Direct Costs incurred by an Other Claims Service Provider to perform the Statement of Work, operating at Best Industry Practice; and

(B) the actual incremental Direct Costs incurred by the Claims Service Provider to perform the Statement of Work; and

(ii) the Claims Service Provider will be entitled to charge icare for its performance of any other activities under the Delivery Proposal up to the lesser of:

(A) the amount icare reasonably believes would be the incremental Direct Costs incurred by an Other Claims Service Provider to perform those other activities, operating at Best Industry Practice; and

(B) the actual incremental Direct Costs incurred by the Claims Service Provider to perform those other activities,

except that:

(iii) the Claims Service Provider will not be entitled to any payment under clause 39.4(a)(ii) if clause 39.3(c) applies and icare has amended the remuneration model under section 11.5 (External Factor Response by icare) of Schedule 2 ("Remuneration"); and

(iv) where the Claims Service Provider is entitled to charge icare under this clause 39.4(a) for its performance of a Non-material Project, it will only be allowed to charge that part of the applicable amount that, in aggregate with the incremental Direct Costs incurred by the Claims Service Provider in performing any other Non-material Projects performed and completed in the same Financial Year in order to comply with Chargeable Directions, exceeds the Project Aggregate Threshold.

(b) If clause 40(f) applies in respect of a Material Direction that is a Chargeable Direction, the Claims Service Provider will be entitled to charge icare for its compliance with that Direction up to the lesser of:

(i) the amount icare reasonably believes would be the incremental Direct Costs incurred by an Other Claims Service Provider to comply with that Direction, operating at Best Industry Practice; and

(ii) the actual incremental Direct Costs incurred by the Claims Service Provider to comply with the Direction,

except that where the Claims Service Provider is entitled to charge icare under this clause 39.4(b) for its performance of a Non-material Project, it will only be allowed to charge that part of the applicable amount that, in aggregate with the incremental Direct Costs incurred by the Claims Service Provider in performing any other Non-material Projects performed and completed in the same Financial Year in order to comply with Chargeable Directions, exceeds the Project Aggregate Threshold.

(c) The parties agree that:

(i) clauses 39.4(a) and 39.4(b) do not operate to limit the Claims Service Provider's entitlement to payment for activities in relation to Material Regulatory Changes under clause 38.3; and

(ii) the Claims Service Provider cannot claim payment for the same activities under both clause 38.3 and clause 39.4.

40. Delivery Proposals

(a) If the parties agree or it is resolved that:

(i) a Material Regulatory Change has occurred or is likely to occur to which either or both of clauses 38.1(a) and 38.1(b) apply; or

(ii) icare has issued a Material Direction to which either or both of clauses 39.2(a) and 39.2(b) apply,

then the Claims Service Provider will develop and issue for icare's approval a proposal for the implementation of the Material Regulatory Change or Material Direction (as applicable) which will include:

(iii) in respect of any Material Project referred to in clause 38.1(a) or 39.2(a)(i) or Non-material Project referred to in clause 39.2(a)(ii) (as applicable), a draft Statement of Work to which the terms of sections 2 to 4 of Schedule 4 ("Project Services Framework") will apply;

(iv) in respect of any changes referred to in clause 38.1(b) or 39.2(b) (as applicable), details of:

(A) the nature of those changes (including any amendments required to the Contract to reflect those changes);

(B) any Deliverables to be provided; and

(C) any acceptance test plan required;

(v) any other detail that icare reasonably requests; and

(vi) in respect of:

(A) a Material Regulatory Change; or

(B) a Material Direction that is a Chargeable Direction,

the incremental Direct Costs it estimates it will incur to perform the proposed Material Project referred to in clause 39.2(a)(i) or Non-material Project referred to in clause 39.2(a)(ii) (as applicable) and other proposed activities,

(a **Delivery Proposal**).

(b) icare must reasonably consider each Delivery Proposal, but may:

(i) approve the Delivery Proposal;

(ii) reject the Delivery Proposal; or

(iii) require reasonable adjustments to the Delivery Proposal.

(c) If icare requires reasonable adjustments to the Delivery Proposal under clause 40(b)(iii), then the Claims Service Provider will reflect these adjustments in a revised Delivery Proposal, and resubmit it to icare promptly, and the process in clause 40(b) will apply.

(d) The parties acknowledge and agree that Project Services (and associated Deliverables) to be provided under an approved Delivery Proposal may be subject to an alternative Intellectual Property Rights ownership and licensing model from that set out in clauses 33.1 to 33.4, except that Records, and Intellectual Property Rights in Records, are the property of icare, and will, on creation, vest in icare.

(e) If icare Approves a Delivery Proposal, then:

(i) the Delivery Proposal (including any approved Statement of Work and any approved amendments to the Contract) will form part of this Contract;

(ii) in undertaking the Statement of Work the Claims Service Provider must use a project management methodology that meets the requirements of

clause 11.1(c) as if the services in the Statement of Work were Project Services requested under clause 11; and

(iii) the Claims Service Provider must comply with that Delivery Proposal (including any approved Statement of Work and applicable Project Plan and the applicable provisions set out in Schedule 4 ("Project Services Framework")) and implement its requirements.

(f) If:

(i) a Material Direction is specified to be an Urgent Direction; or

(ii) a Delivery Proposal in respect of a Material Direction has not been approved within 20 Business Days of icare's receipt of the Claims Service Provider's first draft of the Delivery Proposal, or such other period as the parties may agree, acting reasonably,

then the Claims Service Provider must, if requested by icare, immediately comply with the relevant Direction.

41. Other changes

41.1 Changes to Contract Terms, and Schedule 2 ("Remuneration")

Notwithstanding any other provision of this Contract, the parties agree that:

(a) any variation to:

(i) the Contract Terms; or

(ii) the Contract Details, excluding items 8, 9, 10, 11, and 12 which may be agreed by the parties in writing or under an existing mechanism in the Contract,

can only be effected by way of a variation agreement executed by both parties under clause 62.7, except that a definition in clause 64.1 for a term used in a Schedule or Attachment may be changed solely as it relates to that Schedule or Attachment in the same manner that the relevant Schedule or Attachment may be changed under this Contract;

(b) any variation to Schedule 2 ("Remuneration"), including its Attachments, can only be effected as permitted under Schedule 2 ("Remuneration"), clause 41.3 (Changes to Outcome Measures) or clause 41.4 (Changes to Operational Measures and Quality Measures), or by way of a variation agreement executed by both parties under clause 62.7; and

(c) nothing in this clause 41 or clause 62.7 limits icare's ability to change Schedules or Attachments in accordance with the terms of those Schedules or Attachments.

41.2 Changes to Manuals, icare Policies, icare Operational Materials, Claims RACI, Schedules and Attachments

(a) Subject to clause 41.1, icare may from time to time:

(i) issue a notice to the Claims Service Provider advising of:

(A) a change to the, or new, icare Operational Materials; or

(B) an immaterial change to a Manual, icare Policy, Claims RACI, Schedule or Attachment (other than Schedule 2 or an Attachment to Schedule 2),

(an **Update Notice**); or

(ii) issue a notice to the Claims Service Provider advising of:

(A) a material change to a Manual, icare Policy, Claims RACI, Schedule or Attachment (other than Schedule 2 or an Attachment to Schedule 2, or Attachment 3.01 (Operational Measures)); or

(B) a new Manual, icare Policy, Schedule or Attachment (other than Schedule 2 or an Attachment to Schedule 2, or Attachment 3.01 (Operational Measures)),

(a **Notice of Change**),

and in each case requiring the Claims Service Provider to comply with the new or changed Manual, icare Policy, icare Operational Materials, Claims RACI, Schedule or Attachment.

(b) An Update Notice or Notice of Change issued under clause 41.2(a) will be treated as a Direction issued under clause 39.1(a) and will be subject to clause 39. For the purposes of clause 39.2, an Update Notice will in no circumstances be considered a Material Direction.

(c) Except as contemplated in this Section J- Directions and Change Management of this Contract, in no circumstances will icare be required to pay any fee or compensation to the Claims Service Provider in relation to the implementation of any Update Notice or Notice of Change issued under clause 41.2(a).

(d) icare may, at its sole discretion, invite the Claims Service Provider to provide written comments to icare on any proposed changes to the icare Operational Materials or a Manual, icare Policy, Claims RACI, Schedule or Attachment (other than Schedule 2 or an Attachment to Schedule 2, or Attachment 3.01 (Operational Measures)), as applicable. icare is not bound to accept or act on any of the Claims Service Provider's comments.

41.3 Changes to Outcome Measures

The parties agree that any variation to the Outcome Measures can only be effected:

(a) in accordance with Schedule 2 (“Remuneration”) or Schedule 3 (“Performance Management & Governance”); or

(b) by way of a variation agreement executed by both parties under clause 62.7.

41.4 Changes to Operational Measures and Quality Measures

(a) Without limiting icare’s right to change Quality Measures and Operational Measures in accordance with Schedule 2 (“Remuneration”) or Schedule 3 (“Performance Management & Governance”) respectively, icare may during the Term, by notice to the Claims Service Provider (**Notice of Measure Change**), change the Operational Measures and Quality Measures (collectively **Measures**), including the method of measuring the performance of the Claims Service Provider in respect of any of

those Measures, and require the Claims Service Provider to comply with the updated Measure.

(b) The Claims Service Provider acknowledges and agrees that it will be bound by the provisions of or changes to any Measures from the implementation date specified in the Notice of Measure Change.

(c) A Notice of Measure Change issued under clause 41.4(a) will be treated as a Direction issued under clause 39.1(a) and will be subject to clause 39. For the purposes of clause 39.2, any changes (including increases) to reporting requirements associated with Measures that are introduced by a Notice of Measure Change will not be a factor in any assessment of whether the Notice of Measure Change is a Material Direction.

(d) Except as contemplated in this Section J- Directions and Change Management of this Contract, in no circumstances will icare be required to pay any fee or compensation to the Claims Service Provider in relation to the implementation of any Notice of Measure Change issued under clause 41.4.

42. Changes to WH&S and Workers Compensation Legislation

Except as contemplated in this Section J- Directions and Change Management, under no circumstances will icare be required to pay any fee or compensation to the Claims Service Provider in relation to changes to or the implementation of any new or updated Law, including changes to WH&S and Workers Compensation Legislation, during the Term.

SECTION K - Governance, reporting and audit

43. Authorised Representatives

43.1 Identity and role

The identity, roles and responsibilities of the:

(a) Claims Service Provider Authorised Representative; and

(b) icare Authorised Representative,

are primarily set out in this clause 43 and Schedule 3 (“Performance Management & Governance”).

43.2 Claims Service Provider Authorised Representative – requirements, authority and availability

(a) The Claims Service Provider Authorised Representative must:

(i) be Approved by icare, with such Approval not to be unreasonably withheld; and

(ii) be available to attend or participate in meetings at a location, or by such technological means, as reasonably required by icare from time to time.

(b) In determining whether to Approve the appointment of an Authorised Representative, icare may have regard to the disqualification register maintained by APRA and the banned and disqualified persons register maintained by ASIC, or any similar register maintained by these or any successor regulators, among other matters.

(c) The Claims Service Provider agrees that the Claims Service Provider Authorised Representative is authorised and empowered to act on behalf of and bind the Claims Service Provider in all matters arising between the parties and for the purposes of any act, matter or thing to be done by the Claims Service Provider arising out of or in connection with this Contract.

(d) The Claims Service Provider Authorised Representative must be available at all reasonable times for consultation with icare in connection with any matter arising out of or in connection with this Contract.

(e) Matters within the knowledge of the Claims Service Provider Authorised Representative will be deemed to be within the knowledge of the Claims Service Provider.

43.3 icare Authorised Representative

(a) icare must:

(i) ensure there is an icare Authorised Representative appointed at all times; and

(ii) notify the Claims Service Provider within ten Business Days of a change to its icare Authorised Representative.

(b) icare agrees that the icare Authorised Representative is the agent of icare, for the purposes of any act, matter or thing to be done by icare arising out of or in connection with this Contract.

43.4 Delegation by icare Authorised Representative

(a) The icare Authorised Representative may delegate any powers, duties and functions under this Contract to other employees or agents of icare and the Claims Service Provider acknowledges that there may be more than one delegation by the icare Authorised Representative.

(b) icare must keep the Claims Service Provider advised of the identities and delegated authorities of such persons.

43.5 Compliance with requirements or instructions of delegates

The Claims Service Provider must comply with any requirements, instructions or the like, given to it by any of the icare Authorised Representative's delegates, in accordance with their delegated authorities, as if they were requirements or instructions given to it by the icare Authorised Representative.

44. Partnering and Performance Managers

44.1 Identity and role

The identity, roles and responsibilities of the:

(a) icare Partnering and Performance Manager; and

(b) Claims Service Provider Partnering and Performance Manager,

including with respect to meetings, are primarily set out in this clause 44 and Schedule 3 ("Performance Management & Governance").

44.2 icare Partnering and Performance Manager

icare will nominate an icare Partnering and Performance Manager to manage the operation of this Contract for icare and to represent icare (either in person or through his or her delegate) in all day to day dealings with the Claims Service Provider, in accordance with Schedule 3 ("Performance Management & Governance").

44.3 Claims Service Provider Partnering and Performance Manager

(a) The Claims Service Provider Partnering and Performance Manager must:

(i) be Approved by icare, with such Approval not to be unreasonably withheld; and

(ii) be available to attend or participate in meetings at a location, or by such technological means, as reasonably required by icare from time to time.

(b) In determining whether to Approve the appointment of a Claims Service Provider Partnering and Performance Manager, icare may have regard to the disqualification register maintained by APRA and the banned and disqualified persons register maintained by ASIC, or any similar register maintained by these or any successor regulators, among other matters.

(c) The Claims Service Provider Partnering and Performance Manager will manage the operation of this Contract for the Claims Service Provider and represent the Claims Service Provider in all day to day dealings with icare, in accordance with Schedule 3 ("Performance Management & Governance").

(d) The Claims Service Provider agrees that the Claims Service Provider Partnering and Performance Manager is authorised and empowered to act on behalf of and bind the Claims Service Provider in all matters arising between the parties and for the purposes of any act, matter or thing to be done by the Claims Service Provider arising out of or in connection with this Contract.

(e) Matters within the knowledge of the Claims Service Provider Partnering and Performance Manager will be deemed to be within the knowledge of the Claims Service Provider.

44.4 Role of Claims Service Provider Partnering and Performance Manager

The Claims Service Provider Partnering and Performance Manager will:

(a) be the primary point of contact for icare for the purposes of this Contract;

(b) have the authority and be given the responsibility to perform each of the tasks, activities and accountabilities allocated to them in Schedule 3 (“Performance Management & Governance”);

(c) be a full-time employee of the Claims Service Provider or Service Company of the Claims Service Provider; and

(d) have a strong working knowledge of the Claims Service Provider’s business operations and the Workers Compensation Scheme Principles and how they interrelate.

44.5 Meetings

(a) icare will establish the Meetings specified in Schedule 3 (“Performance Management & Governance”).

(b) The Meetings will:

(i) consist of Personnel from icare's organisation and the Claims Service Provider's organisation and will carry out the responsibilities set out in Schedule 3 (“Performance Management & Governance”); and

(ii) take place at the times and locations agreed by the parties in accordance with Schedule 3 (“Performance Management & Governance”).

(c) The Claims Service Provider will attend and participate in the Meetings and perform all related obligations as set out in Schedule 3 (“Performance Management & Governance”).

44.6 Meetings of Claims Service Provider Partnering and Performance Manager and icare Partnering and Performance Manager

The Claims Service Provider Partnering and Performance Manager and icare Partnering and Performance Manager will meet at the times and locations agreed by the parties, unless otherwise required by icare.

45. Reporting

45.1 Measurement systems and reporting

The Claims Service Provider must ensure that its measurement and monitoring systems will permit accurate and consistent reporting at a level of detail that is reasonably necessary to monitor and report on the Claims Service Provider's requirements under this Contract and as otherwise determined by icare.

45.2 Required reports

The Claims Service Provider must provide:

(a) reports in accordance with this Contract, the Schedules, and any Statement of Work, and such other reports (including any reports requested by icare to be provided to Parliament, any Parliamentary Committee, any Minister, or any Government Agency that has the right or need to request information from icare) as may be specified by icare from time to time, in accordance with the timeframe for

reporting set out in this Contract, the Schedules, a Statement of Work or as otherwise reasonably requested by icare;

(b) any reports in such a form that they are readily understandable by icare and can be readily communicated to icare and its Personnel; and

(c) detailed supporting information for each report as reasonably required by icare from time to time.

46. Records, inspections and audits

46.1 Record Keeping

The Claims Service Provider must maintain proper Documentation, books, accounts and Records relating to the Services during the Term and for a further period of not less than seven Years from the end of the Term, including those items set out in clause 46.2 and any items referred to in Schedule 3 ("Performance Management & Governance") in accordance with the Law.

46.2 Access to premises, Personnel, systems and information

(a) The Claims Service Provider must, at all reasonable times, provide icare and icare's nominee with:

(i) information and Documentation; and

(ii) where icare reasonably requires, access to any Approved Location, Personnel, Equipment, and systems,

relating to this Contract or the Services, for inspection and audit, including:

(iii) compliance with the Transition-In Plan;

(iv) Claims files;

(v) books, accounts, and Records;

(vi) receipts into or payments out of any icare (or Relevant Fund) bank account;

(vii) correspondence in relation to Claims received or sent by the Claims Service Provider;

(viii) Claims Service Provider Material or Project Material and Records;

(ix) Claims Service Provider Operational Data;

(x) Equipment used to provide the Services;

(xi) contracts with:

(A) Subcontractors;

(B) Key Input Providers; and

(C) any Third Party Service Providers that are appointed by the Claims Service Provider in its capacity as agent for icare;

(xii) reports and other Documentation prepared in connection with any reviews and other assurance activities undertaken by the Claims Service Provider or

the Claims Service Provider's auditors under clause 46.4 and Schedule 3 ("Performance Management & Governance");

(xiii) reports and other Documentation prepared in connection with the Claims Service Provider's Quality Management Framework under Schedule 3 ("Performance Management & Governance");

(xiv) within ten Business Days (or such longer period as icare may allow) of receiving a notice from icare – all Documentation that is reasonably necessary to enable the incremental Direct Cost of a Project Service to be verified by icare and/or an auditor appointed by icare, and

(xv) all other Documents or Records as icare may direct from time to time.

(b) The Documentation or information described in this clause 46.2 must be made available on icare's request. icare and/or its appointed representative may make copies, in any form, of any of the Documentation or information referred to in this clause 46.2.

46.3 Claims Service Provider external audit requirements

icare will appoint an independent qualified auditor (which for the avoidance of doubt must not be the Claims Service Provider's internal or external auditor) (**Approved Auditor**) to oversee the books, Records, and systems of the Claims Service Provider to determine whether:

(a) the Claims Service Provider is accurately recording and accounting for icare's monies and other assets;

(b) icare's obligations to report to the relevant tax authority or other Government Agency are properly met; and

(c) the Claims Service Provider has adequate Internal Controls.

46.4 Claims Service Provider internal reviews and assurance requirements

(a) The Claims Service Provider's qualified internal auditor must undertake reviews and other assurance activities required by and in accordance with Schedule 3 ("Performance Management & Governance"), including those relating to the Claims Service Provider's performance against the Performance Measures.

(b) Where the Claims Service Provider does not have access to a qualified internal auditor to meet the requirements of clause 46.4(a), the Claims Service Provider must procure an independent qualified auditor to undertake the reviews and other assurance activities detailed in Schedule 3 ("Performance Management & Governance") on its own behalf.

46.5 Audit and inspection by icare – general

In addition to the reviews and other assurance requirements referred to in clause 46.4 and in Schedule 3 ("Performance Management & Governance"), icare may, at any time subject to clause 46.7, acting reasonably:

(a) conduct random inspections and tests of the:

(i) performance of the Services;

(ii) training, competency and tenure of the Claims Service Provider's Personnel;

(iii) evidence of the Business Continuity Plan (including evidence of the Claims Service Provider's own and testing);

(iv) the utilization of the Claims Service Provider's risk management policies;

(v) internal financial controls; and

(vi) books, accounts and Records for any purposes, including to determine how the Remuneration, Third Party SP Payments, Benefits or any other payments have been made or accounted for, how Conflicts are managed and the financial standing of the Claims Service Provider;

(b) conduct random audits to determine the Claims Service Provider's compliance with the requirements of this Contract relating to:

(i) Data protection;

(ii) Data maintenance; and

(iii) Data transfer;

(c) test, and conduct audits of the Claims Service Provider's information security controls, procedures, systems, networks and facilities in scope of the Services;

(d) conduct random audits to determine compliance with this Contract (including compliance with icare Policies, Manuals and icare Operational Materials) and the adequacy of processes and methods put in place by the Claims Service Provider in performing the Services; and

(e) conduct any other tests or inspection that icare considers necessary to ascertain whether or not the Claims Service Provider is complying with its obligations under this Contract.

46.6 Audit and inspection by icare – security audit

(a) The Claims Service Provider agrees that icare or icare's nominee may, at any time, with reasonable notice:

(i) subject to clause 46.6(b), conduct a security audit of the Claims Service Provider's compliance with clause 55; and

(ii) require that the Claims Service Provider provides (at the Claims Service Provider's election and cost) either a ISAE3402 Type II or a SOC2 report on the information security controls in place in relation to information technology systems used by the Claims Service Provider in its performance of the Services,

in each case not more than once per Financial Year.

(b) icare will, where practicable, consult with the Claims Service Provider regarding the Claims Service Provider's preferred times, location and scope, prior to issuing any notice under clause 46.6(a)(i).

46.7 Scope of audit

(a) The scope of any test, inspection or audit undertaken by icare under clause 46 will be determined by icare.

(b) icare will, where practicable, exercise its audit and inspection rights under this clause 46 in a manner that is not intended to delay or disrupt in any material respect the Claims Service Provider's ability to provide Services in accordance with this Contract.

(c) Nothing in clause 46 permits icare to conduct penetration or vulnerability testing of the Claims Service Provider's information systems. If requested the Claims Service Provider must provide icare with a copy of its most recent penetration or vulnerability testing results.

46.8 Overriding Obligation

None of the reviews, assurance activities, tests, inspections or audits referred to in clause 46.3, 46.4 or 46.5 or Schedule 3 ("Performance Management & Governance"), detract from the Claims Service Provider's responsibility to ensure that its Personnel adopt safe working practices and to carry out appropriate training, supervision, inspection and audit to ensure that this is done.

46.9 No advance notice of inspections, tests or audits

The Claims Service Provider must not give the Personnel advance notice of inspections, tests or audits referred to in clause 46.5 without the Approval of the icare Authorised Representative, except as required to ensure appropriate resource availability.

46.10 Co-operation

The Claims Service Provider must, and must procure that any Personnel and Service Company must, at its own cost, fully co-operate with representatives of icare conducting, reviewing, or making any inspection, test or audit under this Contract, including providing such access to its Equipment, Approved Location and Personnel as is required by icare.

46.11 Who may carry out inspections, tests or audits

icare may conduct any inspection, test or audit referred to in clause 46.5 itself, or appoint any other suitably qualified person to conduct the inspection, test or audit.

46.12 Cost of inspections, test and audits – Claims Service Provider

The costs of the reviews and assurance activities referred to in clause 46.4 and Schedule 3 ("Performance Management & Governance") that must be undertaken by the Claims Service Provider or the Claims Service Provider's auditor will be borne by the Claims Service Provider.

46.13 Cost of inspections, test and audits – icare

The costs of each inspection, test and audit carried out by icare, icare's auditor or the Approved Auditor in accordance with clauses 46.3 and 46.5 and Schedule 3 ("Performance Management & Governance") (excluding any costs incurred by the Claims Service Provider

in complying with this clause 46 and Schedule 3 ("Performance Management & Governance")) will be borne by icare unless the inspection, test or audit reveals either:

(a) a material breach of the Contract;

(b) incorrect payment by more than 5% of:

(i) any one of the fees listed in clause 13.1; or

(ii) any other amount payable to icare by the Claims Service Provider where the cause of incorrect payment is, or has been contributed to, by the Claims Service Provider; or

(c) incorrect amounts:

(i) payable to Workers, by more than 1% of the total of all of the payments made by the Claims Service Provider to Workers for the period that was subject to the inspection, test or audit; or

(ii) collectable from Employers, by more than 1% of the total of all of the amounts collectable by the Claims Service Provider from Employers for the period that was subject to the inspection, test or audit,

in which case the Claims Service Provider indemnifies icare for all costs of the inspection, test or audit.

46.14 Implementation of Recommendations

(a) icare may direct the Claims Service Provider to implement any recommendations made by icare's auditor within the timeframe directed by icare.

(b) A direction issued under clause 46.14(a) will be treated as a Direction issued under clause 39.1(a) and will be subject to clause 39. Except as contemplated in Section J- Directions and Change Management of this Contract, in no circumstances will icare be required to pay any fee or compensation to the Claims Service Provider in relation to a direction issued under clause 46.14(a).

46.15 NSW Auditor General

(a) Without limiting its obligations at Law, the Claims Service Provider must permit the NSW Auditor General to conduct audits and reviews of the Claims Service Provider and the Services of a nature equivalent or similar to those described under clauses 46.3, 46.4 and 46.5 and Schedule 3 ("Performance Management & Governance").

(b) icare will use its best endeavours to provide the Claims Service Provider with two Business Days' notice of any audit by the NSW Auditor General.

46.16 Confidential Information

(a) icare must take all reasonable steps to ensure that any of the Claims Service Provider's Confidential Information that is disclosed to any representative or auditor under this clause 46 (other than the NSW Auditor General who will be bound by the obligations at Law) is treated as confidential.

(b) The Claims Service Provider must take all reasonable steps to ensure that any of icare's Confidential Information that is disclosed to any auditor under this clause 46 is treated as confidential.

46.17 Rights of icare where Key Input Provider provides part of all of the Services

The Claims Service Provider must ensure that:

(a) icare has the same rights as set out in this clause 46 in respect of any Key Input Provider; and

(b) any Key Input Provider is subject to the same obligations as set out in this clause 46 as if the Key Input Provider was the Claims Service Provider,

so that icare is not disadvantaged in any way by the use of any Key Input Provider providing part or all of the Services.

46.18 SIRA

(a) The Claims Service Provider acknowledges that SIRA may conduct a review, audit or request information pursuant to its legislative powers under the Workers Compensation Laws. Without limiting its obligations at Law, the Claims Service Provider will cooperate with any review, audit or request by SIRA in relation to the Services and will provide access to books, accounts, Data and Records to icare for this purpose.

(b) The Claims Service Provider:

(i) will notify icare:

(A) promptly if it receives a direct request from SIRA arising out of or connected in any way with the Claims Service Provider's role as a Scheme Agent; and

(B) reasonably in advance of:

(I) any provision of access to, or disclosure of, information to SIRA; or

(II) any meeting with SIRA;

(ii) will, if requested by icare:

(A) provide a draft of any communications or other material it intends to provide to SIRA in its capacity as a Scheme Agent; and

(B) reflect any reasonable feedback from icare in the communications or other material that it provides to SIRA;

(iii) will notify icare reasonably in advance of any submission it intends to issue to SIRA in relation to icare, the Services, the Nominal Insurer or the Scheme, consult with icare in relation to the content of that submission prior to its issue, and will not issue that submission without icare's prior written approval; and

(iv) acknowledges that any recommendations or findings from SIRA may be incorporated into a Performance Measure in accordance with Schedule 2 ("Remuneration") and Schedule 3 ("Performance Management & Governance").

Part 6 How we manage our relationship and resolve disputes

Simplified outline of this Part:

This Part 6 contains:

- Section L – Liability and risk management; and
- Section M – Dispute Resolution.

Section L sets out provisions regarding:

- allocation of risk between the parties (including warranties, indemnities, limits on liability, insurance requirements and force majeure);
- management of delays in performance (including appropriate relief for the Claims Service Provider, as well as financial and other consequences of delays);
- remediation procedures in response to breaches of the Contract; and
- information security and operational risk requirements, including business continuity.

Section M sets out provisions regarding dispute resolution, including procedures for resolving disputes between the parties and disputes with Third Parties.

SECTION L - Liability and risk management

47. Claims Service Provider warranties

47.1 General warranties

The Claims Service Provider represents and warrants that:

(a) it has the power to enter into and observe its obligations under this Contract;

(b) it has the licences, consents and authorisations necessary to enter into and perform its obligations under this Contract. The Claims Service Provider will provide icare with copies of Documents relating to the relevant licences, consents and authorisations on request;

(c) it is registered under the GST Act;

(d) the signing of, or performance of its obligations under, this Contract will not violate any judgement, order or decree, nor be a material default under any material contract by which its assets are bound;

(e) it has examined and acquired actual knowledge of this Contract, all information provided to the Claims Service Provider prior to signing this Contract (in connection with the Contract), the Services and any other information made available to the Claims Service Provider whether by icare or from any other source;

(f) it has examined and taken into consideration all information which is relevant to the risks, contingencies and other circumstances which could in any way affect the Claims Service Provider's decision to offer, enter into or accept this Contract;

(g) it has informed itself of the nature of the Services;

(h) it did not rely on any express or implied statement, warranty or representation, whether oral or written, made by or on behalf of icare that is not expressly contained in this Contract, including as to any level of profitability, or estimated or expected revenue, that will be provided by the Remuneration;

(i) the provision of Services and Deliverables to icare, and the use of the Services and Deliverables by icare will not infringe the Intellectual Property Rights or Moral Rights of any person;

(j) it has the necessary rights to vest the Intellectual Property Rights and grant the licences as provided in clause 33; and

(k) anything done by the Claims Service Provider in the course of the provision of the Services and the Deliverables will not infringe the Intellectual Property Rights or Moral Rights of any person.

47.2 Warranties regarding Services

The Claims Service Provider represents and warrants that:

(a) it will ensure its Personnel (and the Personnel of any Service Company involved in providing the Services) have adequate and continuous relevant training; and

(b) the Services:

(i) are fit for the purposes for which they are supplied; and

(ii) will be provided in accordance with all Laws and this Contract.

47.3 Further warranties

Throughout the Term, the Claims Service Provider represents and warrants that:

(a) the Claims Service Provider and its Personnel (and the Personnel of any Service Company involved in providing the Services) have the relevant time, resources, capacity, expertise, capability, licences, qualifications, and ability to provide the Services to meet their obligations under the Contract;

(b) it and any Service Company will promptly pay all:

(i) payroll tax;

(ii) superannuation contributions;

(iii) applicable workers compensation insurance; and

(iv) remuneration,

that is due in accordance with Law to its employees and contractors; and

(c) any Documentation given by the Claims Service Provider to icare (and/or an auditor appointed by icare), including under clause 36.2 is true, correct and not misleading.

47.4 Warranties as to systems and Equipment

Throughout the Term the Claims Service Provider represents and warrants that:

(a) it will maintain and comply with all licensing arrangements, as necessary, to ensure that Equipment can be used in connection with the Services; and

(b) it will actively monitor the use of its Equipment, processes and systems and those of any Service Company involved in providing the Services to prevent their use for any illegal activity or unauthorised transactions.

47.5 Requirements and condition of disclosure

(a) The Claims Service Provider must during the Term notify and fully disclose to icare in writing within two Business Days of the occurrence of the following matters:

(i) any litigation or proceeding whatsoever, actual or threatened, against the Claims Service Provider or Service Company and/or their respective Personnel (including its Key Personnel) that are involved in providing the Services under this Contract but only insofar as such litigation or proceeding:

(A) would adversely impact the Claims Service Provider's ability to:

(I) deliver the Services;

(II) conduct its business operations; or

(III) manage its risks effectively; or

(B) has had or could have an adverse effect on the reputation of the Claims Service Provider or any Service Company involved in providing the Services, the Guarantor or any of their respective Related Bodies Corporate;

(ii) the existence of any breach or default or alleged breach or default of any agreement, order or award binding on the Claims Service Provider or any Service Company and/or their respective Personnel (including its Key Personnel) that are involved in providing the Services under this Contract but only insofar as such breach or default or alleged breach or default:

(A) would adversely impact the Claims Service Provider's ability to:

(I) deliver the Services;

(II) conduct its business operations; or

(III) manage its risks effectively; or

(B) has had or could have an adverse effect on the reputation of the Claims Service Provider or any Service Company involved in providing the Services, the Guarantor or any of their respective Related Bodies Corporate;

(iii) any notice, report or other correspondence that the Claims Service Provider, the Guarantor or Service Company involved in providing the Services provides to, or receives from, any securities exchange, ASIC, APRA or any

other regulatory body in Australia, where that notice, report or correspondence relates to any of the following:

(A) a material breach or likely material breach of any applicable legislation or prudential standard, but only insofar as such material breach or likely breach would adversely impact the Claims Service Provider's ability to:

(I) deliver the Services;

(II) conduct its business operations; or

(III) manage its risks effectively; or

(B) subject to 47.5(a)(iii)(A), the authority of the Claims Service Provider to conduct its business; and

(iv) any matter or event that a reasonable person in the position of the Claims Service Provider would believe:

(A) has resulted in or may result in the occurrence of one or more of the matters described in clauses 59.2(b)(i), 59.2(b)(ii), 59.2(b)(iii), 59.2(b)(iv), or 59.2(i); or

(B) has had or could have a material adverse effect on:

(I) the ability of the Claims Service Provider (or any Service Company involved in providing the Services) to perform its obligations under the Contract, including the provision of the Services; or

(II) the reputation of the Claims Service Provider or any Service Company involved in providing the Services, the Guarantor or any of their respective Related Bodies Corporate.

(b) The Claims Service Provider must during the Term notify and fully disclose to icare in writing of the occurrence of matters relating to the commercial, technical or financial capacity of the Claims Service Provider or any Service Company involved in providing the Services and their respective Personnel (including its Key Personnel) that are proposed to be engaged in respect of this Contract, which has had or could have a material adverse effect on:

(i) the ability of the Claims Service Provider (or any Service Company involved in providing the Services) to perform its obligations under the Contract, including the provision of the Services; or

(ii) the reputation of the Claims Service Provider or any Service Company involved in providing the Services, the Guarantor or any of their respective Related Bodies Corporate.

47.6 No liability on Claims Service Provider where error not detected by due diligence

Nothing in this clause 47 is intended to make the Claims Service Provider liable for errors in information provided by the Claims Service Provider which the Claims Service Provider could not detect using reasonable diligence.

48. icare's warranties / disclaimer

48.1 Representations and warranties

icare represents and warrants to the Claims Service Provider that:

(a) icare has the requisite power and authority to enter into this Contract; and

(b) icare is registered under the GST Act and will remain registered throughout the Term.

48.2 Facilities and resources on 'as is' basis

To the extent that icare licenses, provides or otherwise makes available any facilities or resources to the Claims Service Provider under this Contract (collectively the **"icare Resources"**) they are provided to the Claims Service Provider on an 'as is' basis, and the Claims Service Provider acknowledges and accepts that, to the extent permitted by Law, no representation has been made and no warranty is or has been expressly or impliedly given by or on behalf of icare or its Personnel in respect of the condition, state of repair, quality, fitness for purpose or merchantability of any icare Resources.

49. Indemnity

49.1 Indemnity

(a) To the maximum extent permitted by Law, the Claims Service Provider indemnifies and will keep indemnified icare, its Personnel, its successors and assigns ("**those indemnified**") against any Demand incurred or suffered by any of those indemnified to the extent that those indemnified incur liability by reason of:

(i) the Claims Service Provider exceeding its authority as agent of icare;

(ii) any breach of any Laws by:

(A) icare or its Personnel that is caused or contributed to by the Claims Service Provider or any Service Company involved in providing the Services or their Personnel; or

(B) the Claims Service Provider or its Related Bodies Corporate or any Service Company and/or their respective Personnel applicable to the Services and the performance of the obligations under this Contract;

(iii) any act or omission of the Claims Service Provider, or any Service Company involved in providing the Services or their Related Bodies Corporate or their respective Personnel that causes or contributes to personal injury (including sickness) to, or the death of, any person;

(iv) any act or omission of the Claims Service Provider, or any Service Company involved in providing the Services or their Related Bodies Corporate or their respective Personnel resulting in loss of, or damage to, tangible property;

(v) any Wilful Misconduct of the Claims Service Provider, or any Service Company involved in providing the Services or their Related Bodies Corporate or their respective Personnel;

(vi) Fraud by the Claims Service Provider or any Service Company involved in providing the Services or their Related Bodies Corporate, their respective Personnel or their respective directors, officers and employees;

(vii) Fraud by Third Party Service Providers or their respective Personnel, Employers or Workers to the extent that the Claims Service Provider failed to provide Fraud prevention and detection procedures in accordance with this Contract, and had such procedures been in place the amounts lost would not have been likely to have been lost; or

(viii) a breach of any obligation of confidence or privacy by the Claims Service Provider or any Service Company involved in providing the Services, their Related Bodies Corporate or their respective Personnel.

(b) The Claims Service Provider's liability to indemnify those indemnified under this Contract will be reduced proportionally to the extent that any unlawful, wilful or negligent act or omission of icare or breach of this Contract by icare caused or contributed to the liability or loss.

49.2 Indemnification procedures

(a) If a Demand is made against those indemnified under clause 49.1, icare must:

(i) notify the Claims Service Provider in writing of the Demand, as soon as practicable;

(ii) give the Claims Service Provider the option to conduct the defence of the Demand; and

(iii) provide the Claims Service Provider with all assistance it reasonably requests in conducting the defence of the Demand, at the Claims Service Provider's expense.

(b) If the Claims Service Provider assumes the defence of a Demand in accordance with clause 49.2(a), the Claims Service Provider must:

(i) comply with the model litigant policy and at all times have regard for interests and reputation of those indemnified;

(ii) consult with those indemnified and keep those indemnified informed in relation to any negotiations or litigation;

(iii) not enter into any settlement or compromise of a Demand that involves a remedy other than the payment of money by the Claims Service Provider, without the prior written consent of those indemnified, such consent not to be unreasonably withheld; and

(iv) comply with the reasonable requirements of those indemnified relating in any way to the defence of or negotiations for settlement of the Demand.

(c) If the Claims Service Provider does not assume full control over the defence of a Demand under clause 49.2(a) within a reasonable time, those indemnified may defend the Demand in such manner as they may deem appropriate, at the Claims Service Provider's expense.

49.3 icare requirements

icare must, and must ensure that each of those indemnified will, use its best endeavours to mitigate its liabilities incurred or suffered in connection with the Demand.

49.4 Indemnity relating to Intellectual Property Rights

(a) The Claims Service Provider must indemnify icare and its Personnel, successors and assigns ("**those indemnified**") against loss, damage or expense that has been incurred by those indemnified as the result of a Demand made by a third party where that loss, damage or expense arises from a Demand made against those indemnified in which it is alleged that the Services or any Deliverable, including the use of the Services or Deliverable, in accordance with this Contract infringes the Intellectual Property Rights or Moral Rights of any person.

(b) For the purposes of this clause 49.4 an infringement of Intellectual Property Rights includes unauthorised acts which would, but for the operation of:

(i) section 163 of the *Patents Act 1990* (Cth);

(ii) section 96 and/or 96A of the *Designs Act 2003* (Cth);

(iii) section 183 of the *Copyright Act 1968* (Cth); and/or

(iv) section 25 of the *Circuits Layout Act 1989* (Cth),

constitute an infringement.

(c) Although icare may elect to defend a Demand alleging an infringement under this clause 49.4, the Claims Service Provider must, if requested by icare but at the Claims Service Provider's expense, conduct the defence of a Demand alleging such infringement. The Claims Service Provider must comply with icare's requirements relating in any way to that defence or to negotiations for settlement of the Demand.

(d) icare must if requested, but at the Claims Service Provider's expense, provide the Claims Service Provider with reasonable assistance in conducting the defence of such a Demand.

(e) If someone claims, or icare reasonably believes that someone is likely to claim, that all or part of the Foreground Material or Claims Service Provider Material infringe their Intellectual Property Rights, the Claims Service Provider must, in addition to the indemnities under this clause 49.4 and to any other rights that icare may have under or in accordance with this Contract or under general principles of Law, promptly, at the Claims Service Provider's expense:

(i) use its best endeavours to secure the rights for icare to continue to use the affected Foreground Material or Claims Service Provider Material free of any claim or liability for infringement; or

(ii) replace or modify the affected Foreground Material or Claims Service Provider Material, provided that the use of them does not infringe the Intellectual Property Rights of any other person without any degradation of the performance or quality of the affected warranted Materials,

and if the solutions in clauses 49.4(e)(i) or 49.4(e)(ii) cannot be achieved, icare may immediately terminate this Contract for cause under clause 59.2 and pursue all remedies available to it under this Contract and at Law for the Claims Service Provider's material breach of this Contract.

(f) The Claims Service Provider's liability to indemnify those indemnified under this Contract will be reduced proportionally to the extent that any unlawful, wilful or negligent act or omission of icare caused or contributed to the liability or loss.

(g) The indemnity provided under this clause 49.4 does not apply to the extent that the loss, damage or expense arises directly from:

(i) the Claims Service Provider complying with a requirement notified to the Claims Service Provider by icare; or

(ii) the continued use of Foreground Material or Claims Service Provider Material which was replaced by the Claims Service Provider in accordance with clause 49.4(e)(ii).

49.5 Indemnity for penalties

The Claims Service Provider indemnifies icare for any fine, penalty or similar amount imposed on icare by any Government Agency, including under the WH&S and Workers Compensation Legislation, and any costs or expenses incurred by icare to engage a third party to investigate or remediate any issue which has or is likely to result in the imposition of such a fine, penalty or similar amount, due to a breach by the Claims Service Provider under this Contract.

50. Limit of Liability

50.1 Limit of icare's liability

To the maximum extent permitted by Law, the total aggregate liability of icare and its agents (other than the Claims Service Provider or any Other Claims Service Providers) under this Contract in contract, tort (including negligence), breach of statutory duty, at equity, or otherwise for any loss or damage which arises from any Demand arising out of or in connection with this Contract or the relationship between the parties, is limited to $1,000,000.

50.2 Situations in which limit does not apply

The limit of liability in clause 50.1 does not apply to liability arising in relation to:

(a) death or personal injury; or

(b) damage to tangible property,

that was caused by the wilful, or negligent act or omission of icare or its agents (other than the Claims Service Provider or any Other Claims Service Providers); or

(c) a failure to pay any fee or amount set out in clauses 13.1 to 13.2; or

(d) the indemnity under clause 58.5.

50.3 Liability of icare not affected

The parties agree that:

(a) icare's liability to the Claims Service Provider will not be increased in any way as a result of the Claims Service Provider using any Service Company to provide any part of the Services; and

(b) if there is any Demand against icare which includes any Demand from any Service Company, the Claims Service Provider must combine that Demand with any related Demand that the Claims Service Provider may have against icare, and the Claims Service Provider must be the sole representative of any Service Company and/or the Claims Service Provider in a single action.

50.4 Exclusion of Claims Service Provider's liability

Notwithstanding any liability imposed on the Claims Service Provider under this Contract, the parties acknowledge that under section 154G of the 1987 Act, the Claims Service Provider incurs no personal liability for or in connection with a liability incurred by the Claims Service Provider as a Scheme Agent in the exercise of functions in good faith with due care and skill and within the scope of the Claims Service Provider's actual authority to act.

51. Insurance to be maintained by the Claims Service Provider

51.1 Types of insurance

On or prior to the Commencement Date, the Claims Service Provider must effect and must procure that any Key Input Provider effect or be an insured under the following insurances:

(a) public and product liability insurance;

(b) professional indemnity insurance;

(c) fidelity insurance;

(d) cyber liability insurance; and

(e) workers compensation insurance.

51.2 General requirements on Term of insurance

The Claims Service Provider must ensure that each of the insurances that are required are maintained throughout the Term, or for such longer period as is either:

(a) specified below; or

(b) required by Law.

51.3 Specific requirements on Term of insurance

The Claims Service Provider must maintain and must procure that any Key Input Provider maintain professional indemnity insurance for a period ending six Years after the date of provision of the last of the Services, such policy to continue to cover those matters covered by the policy that arise in respect of events or conduct occurring on or prior to the date of

the provision of the last of the Services, subject to the insurance market offering such cover.

51.4 Cover required – general

Unless otherwise Approved by icare, all insurances required to be effected and maintained or required to be procured and maintained by any Key Input Provider by this clause 51 must, to the extent possible or permitted by Law:

(a) cover each insured party individually for their respective rights, interests or liabilities to other parties (as the case may be), including liabilities to any other insured party;

(b) be maintained with an insurer or insurers Approved by icare. Such Approval will be given provided that:

(i) the insurer is independent of any member of the Claims Service Provider Group;

(ii) the insurer is not a captive insurer company of any member of the Claims Service Provider Group; and

(iii) the insurer has the credit rating specified in clause 51.4(c); and

(c) be underwritten by an insurer with “A minus” (or higher), or equivalent, credit rating awarded by a recognised industry rating organisation such as: S&P or Moody’s.

51.5 Cover required – public and product liability

Unless otherwise Approved by icare, the public and product liability insurance required to be effected and maintained under this clause 51 must:

(a) cover each insured party for that party’s liability to any other person for:

(i) loss or damage to property; and

(ii) death or injury to any person;

arising out of or in any way connected with the performance of this Contract or of the functions the subject of this Contract; and

(b) provide insurance cover for an amount in respect of any one occurrence of not less than $20,000,000 with a deductible/excess of no more than $1,500,000.

51.6 Cover required – professional indemnity

(a) Unless otherwise Approved by icare, the professional indemnity insurance required to be effected and maintained under this clause 51 must:

(i) cover each insured party:

(A) for any claim against that party for breach or alleged breach of professional duty;

(B) for any claim against that party for breach or alleged breach of any statutory prohibition against misleading or deceptive conduct; and

(C) for its costs of investigating, settling or defending any claim made against that insured party of a kind referred to in this clause 51.6; and

(ii) provide an indemnity for any one claim or in the annual aggregate the limit of not less than $50,000,000 with a deductible/excess of not more than $10,000,000.

(b) Unless otherwise Approved by icare, the Claims Service Provider must immediately advise icare if the insurer's estimate of the aggregate cost of claims exceeds $10,000,000.

51.7 Cover required – fidelity insurance

(a) Unless otherwise Approved by icare, the fidelity insurance required to be effected and maintained under this clause 51 must:

(i) cover each insured party for loss occasioned by the fraudulent, dishonest or criminal misappropriation of funds by or on behalf of any employee, agent or contractor of the insured party; and

(ii) provide insurance cover for an amount in respect of any one claim of not less than $20,000,000 per claim with a deductible/excess of no more than $5,000,000.

(b) Unless otherwise Approved by icare, the Claims Service Provider must immediately advise icare if the insurer's estimate of the aggregate cost of claims exceeds $10,000,000.

51.8 Cover required – cyber liability

Unless otherwise Approved by icare, the cyber liability insurance required to be effected and maintained under this clause 51 must provide a limit of cover of at least $20,000,000 per claim.

51.9 Cover required – Workers Compensation

The workers compensation insurance required to be effected and maintained by the Claims Service Provider (or by a Related Body Corporate on behalf of the Claims Service Provider) under this clause 51 must insure each insured party, to the extent required by Law, against statutory and common law liability for death of or injury to persons employed by each such insured party.

51.10 Cover required – general requirements

On or before the Commencement Date, and within 20 Business Days of a request in writing by icare, the Claims Service Provider must provide to icare satisfactory evidence of the currency of the insurance policies specified in this clause 51, including:

(a) the amount of the cover;

(b) the identity of the insurer issuing the insurance;

(c) the currency or expiry date of the insurance; and

(d) evidence that the premiums have been paid.

51.11 Claims Service Provider must not jeopardise cover

The Claims Service Provider must not do or omit to do, and must ensure that any Personnel of the Claims Service Provider or any Key Input Provider do not do or omit to do, anything that results in any insurance referred to in this clause 51 being void or voidable, or results in any liability for payment under that policy being reduced.

51.12 Claims Service Provider responsible for any deductible or excess

All deductibles/excess payable under the policies of insurance maintained under this Contract must be paid by the Claims Service Provider.

51.13 Claims Service Provider to give notice

The Claims Service Provider must immediately notify the icare Authorised Representative if:

(a) any of the insurance policies required under this clause 51 are cancelled; or

(b) any matter or event occurs that adversely affects the amount or availability of the Claims Service Provider's cover under the policy.

52. Delays

52.1 Monitoring and managing Delays

The Claims Service Provider must actively monitor and manage:

(a) the Transition-In;

(b) the performance of Project Services;

(c) the performance of the services referred to in paragraph (a) of the definition of Disengagement Services; and

(d) the transfer of Claims,

including:

(e) anticipating and identifying potential failures to meet any relevant deadline or Milestone Date (**Delay**), whether those Delays are caused by the Claims Service Provider (or Claims Service Provider's Personnel), or a Key Input Provider (or its Key Personnel), or a Service Company (or its Personnel), icare or a third party, or any other cause; and

(f) taking reasonable steps to avoid those potential Delays.

52.2 Responding to Actual or Potential Delays

If there is any actual or potential Delay, then:

(a) the Claims Service Provider must immediately notify icare;

(b) the Claims Service Provider must immediately prepare and submit to icare a report identifying the nature and consequences of the Delay;

(c) the Claims Service Provider must inform icare whether:

(i) the Claims Service Provider (or Claims Service Provider's Personnel) will be able to temporarily work around the problem in order to prevent or rectify the Delay; or

(ii) any other person can provide the Services, or part of the Services, in order to prevent, limit or rectify the Delay;

(d) the icare Authorised Representative and Claims Service Provider Authorised Representative (or their nominated representatives) must, if requested to do so by icare, meet within five Business Days after receiving notification of the actual or potential Delay, to discuss how to prevent, limit or rectify the Delay;

(e) the Claims Service Provider must:

(i) prepare and submit regular update reports (as required by icare) in relation to the Delay; and

(ii) take all steps required by icare, including compliance with a direction, to prevent, limit or rectify the Delay, including working cooperatively with Other Claims Service Providers;

(f) if required by icare, the parties must negotiate in good faith to attempt to agree on a temporary workaround plan by the time notified by icare (having regard to the overall time frame and the extent of the Delay) which must set out as a minimum:

(i) the cost implications of the Delay;

(ii) the interdependencies; and

(iii) the expected time impact of the tasks required to rectify the Delay,

and, if agreed, must be signed and dated by the parties; and

(g) the Claims Service Provider must implement and comply with any temporary workaround plans agreed in accordance with clause 52.2(f).

52.3 Status of workaround plan

If the parties agree on a temporary workaround plan in accordance with clause 52.2(f), then that workaround plan will:

(a) be used by the parties to assist to document that workaround;

(b) only operate as a variation of the Contract to the extent that it relates to, and for the duration of, the Delay and does not operate as a waiver of the other obligations that the Claims Service Provider may have under this Contract; and

(c) not limit icare's rights or remedies against the Claims Service Provider in connection with the Delay (for example, to claim damages).

52.4 Consequences of Delay

To the extent a Delay is caused by:

(a) a Force Majeure Event, then the provisions of clause 54 will apply and icare must grant a reasonable extension of time for the relevant deadline or Milestone;

(b) the Claims Service Provider (or Claims Service Provider's Personnel, or Service Company or its Personnel), then icare may, at its election and in addition to requiring the performance of the workaround plan, do one or more of the following:

(i) withhold payment of the applicable Fee until the relevant deadline or Milestone is met;

(ii) claim Liquidated Damages in accordance with clause 52.6;

(iii) specify a revised date for the relevant deadline or Milestone to be met; and

(iv) if a Delay cannot be remedied within a timeframe acceptable to icare (acting reasonably), then this failure will be deemed a breach of this Contract by the Claims Service Provider triggering the Claims Service Provider's obligation to report the breach to icare (and follow the subsequent process) under clause 53.1(a); or

(c) icare or any third party under icare's control and direction (excluding the Claims Service Provider and the Claims Service Provider's Personnel or Service Company and its Personnel), then the Claims Service Provider:

(i) is relieved from its obligations to meet a Milestone affected by the Delay for the duration of the Delay; and

(ii) will be granted an extension of time to perform subsequent obligations impacted by the relevant Delay to the extent of the Delay.

The occurrence of a Delay does not relieve the Claims Service Provider of its obligations to, and the Claims Service Provider must continue to, perform the Services (including Transition-In activities) that are unaffected by the Delay.

52.5 Costs of Delay

The Claims Service Provider will be entitled to recover from icare any direct, incremental and substantiated costs and expenses reasonably incurred by the Claims Service Provider to implement an agreed workaround plan only if:

(a) the Claims Service Provider is entitled to charge or recover costs in respect of the Services in respect of which the Delay occurs (for example, the Claims Service Provider will not be entitled to recover any costs of Delay in respect of Project Services required to implement a Material Direction which is not a Chargeable Direction); and

(b) the Delay is caused by icare or any third party under icare's control and direction (excluding the Claims Service Provider and the Claims Service Provider's Personnel or Service Company and its Personnel).

Except as set out above, any costs and expenses incurred by the Claims Service Provider as a result of the Delay, including to implement any workaround plan will be borne by the Claims Service Provider.

52.6 Liquidated Damages

(a) The parties acknowledge and agree that, if the Claims Service Provider is not able to fully provide the Services by the relevant Milestone Date:

(i) icare will suffer damage; and

(ii) all such damage may not, having regard to the nature of the Services, be able to be precisely calculated or proved; and

(iii) the amount of the liquidated damages if applicable will be calculated in accordance with the Statement of Work, Transition-In Plan, Claims File Transfer Requirements or Disengagement Plan (as applicable) or, if not otherwise specified, negotiated in good faith between the parties.

The parties:

(iv) agree that the amount of liquidated damages that may be specified in the Transition-In Plan, Claims File Transfer Requirements, Disengagement Plan or any Statement of Work (**Liquidated Damages**) will constitute a sum commensurate with icare's interests that will be adversely affected as a result of the provision of the Services not occurring on or before the relevant Milestone Date;

(v) desire to avoid the difficulties of proving damages in connection with such failure and agree that the Liquidated Damages payable by the Claims Service Provider as negotiated between the Claims Service Provider and icare in accordance with this clause 52.6 are not exorbitant, extravagant or unconscionable and do not constitute nor are they intended to be a penalty; and

(vi) agree that the Liquidated Damages payable by the Claims Service Provider under clause 52.6 will be recoverable from the Claims Service Provider as a debt immediately due and payable to icare.

(b) Without limiting any of icare's other rights under the Contract or otherwise but subject to clauses 52.6(d) and 52.6(e), if the Claims Service Provider fails to achieve any Milestone by the relevant Milestone Date, icare will be entitled to recover Liquidated Damages from the Claims Service Provider for each day of the Delay or unavailability.

(c) In recognition of the time-critical nature of the Services and to emphasise the importance to icare of meeting the Final Critical Milestone Date, icare's approach to the application of Liquidated Damages for failure to meet a relevant Milestone will be as set out below:

(i) if the Claims Service Provider fails to meet any Milestone Date, other than the Final Critical Milestone Date, Liquidated Damages will be applied and will accrue as a debt owed to icare;

(ii) if the Claims Service Provider meets the Final Critical Milestone Date, icare will not claim the Liquidated Damages that have accrued under clause 52.6(c)(i); and

(iii) if the Claims Service Provider fails to meet the Final Critical Milestone Date, Liquidated Damages will be applied to that failure and icare will be entitled to recover the Liquidated Damages that apply under clause 52.6(c)(i) and this clause 52.6(c)(iii).

(d) The Claims Service Provider will not be liable to pay any Liquidated Damages arising from the Claims Service Provider's failure to achieve the relevant Milestone Date to the extent that failure arose as a result of:

(i) icare's failure to fulfil its obligations under this Contract;

(ii) an act or omission of any third party (excluding the Claims Service Provider, the Claims Service Provider's Personnel and any Service Company or their Personnel), that is beyond the reasonable control of the Claims Service Provider; or

(iii) an event arising under clause 54.1.

(e) The payment of Liquidated Damages does not relieve the Claims Service Provider from its obligation to provide the Services or from any other obligations or liability under this Contract.

53. Remedies and obligations on a breach of this Contract

53.1 Claims Service Provider's obligations on breach of obligations under this Contract

(a) Every time the Claims Service Provider commits a breach of any of its obligations under this Contract, then the Claims Service Provider must, on becoming aware of such breach, immediately (or at such other time specified in the reporting requirements in this Contract if applicable) report the breach to icare.

(b) Any report required under clause 53.1(a) must be in writing and must contain details of the following matters:

(i) the problem causing the breach and which, if requested by icare, will include a detailed description of a root cause analysis that has been carried out by the Claims Service Provider on the problem causing the breach;

(ii) the status of the breach; and

(iii) the steps being taken to remedy the breach.

(c) Following submission of a report under clause 53.1(a), the Claims Service Provider must promptly:

(i) remedy the breach; and

(ii) except where icare has confirmed in writing that it does not require a Remediation Plan to be implemented, prepare a Remediation Plan for the Approval of icare in accordance with clause 53.2.

(d) For the purposes of clause 53.1(a), the Claims Service Provider is also required to report as soon as reasonably practicable any material breach of obligations by any Service Company, any Third Party Service Provider or any Subcontractor in relation to the Services.

53.2 icare's rights on breach of obligations under this Contract

(a) If the Claims Service Provider breaches any of its obligations under this Contract, and icare, acting reasonably and having regard to historical breaches, considers

that the breach has an adverse effect on the Services and justifies remedial action, icare may issue a direction (**Remediation Plan Direction**) to the Claims Service Provider requiring that the Claims Service Provider submit a draft Remediation Plan, signed by the Claims Service Provider Authorised Representative, within the time period specified in the Remediation Plan Direction.

(b) The draft Remediation Plan must include the matters and items specified in the Remediation Plan Direction and Schedule 3 (“Performance Management & Governance”).

(c) icare will, within ten Business Days of the date on which a draft Remediation Plan is received by icare:

(i) Approve the draft Remediation Plan, in which case the draft Remediation Plan will become a Remediation Plan; or

(ii) acting reasonably, request amendments to the draft Remediation Plan, in which case the Claims Service Provider must make the amendments and resubmit the draft Remediation Plan for icare’s Approval, within five Business Days of receiving the request. If Approved by icare, the amended draft Remediation Plan will become the Remediation Plan.

(d) The Claims Service Provider must, within five Business Days of icare's Approval of the Remediation Plan, provide to icare a copy of the Remediation Plan that has been signed by the Claims Service Provider Authorised Representative (or such other authorised representatives as required by icare).

(e) The Claims Service Provider's obligations under the Remediation Plan commence from the date specified in the Remediation Plan and will not be delayed due to any failure by the Claims Service Provider to obtain the signature of the Claims Service Provider Authorised Representative (or such other authorised representatives as required by icare) as required under clause 53.2(d).

(f) Subject always to clause 53.2(g), if the Claims Service Provider fails to comply with the terms of a Remediation Plan that has been Approved by icare in accordance with this clause 53.2, then icare may:

(i) withdraw or suspend for such period determined by icare, the Claims Service Provider’s authority to handle any Claim; or

(ii) transfer any Claim to icare or any Other Claims Service Provider.

(g) Nothing in this clause 53.2 limits any exercise by icare of its rights under clause 59.2.

53.3 Remediation Plan

If icare Approves a Remediation Plan, this does not constitute a waiver of the breach, nor does it affect icare’s rights if the Claims Service Provider does not meet the requirements of a Remediation Plan that has been Approved prior to receipt of any notice of breach.

53.4 Performance Management Framework

Whilst icare intends to manage the Claims Service Provider’s performance in accordance with Schedule 3 (“Performance Management & Governance”), nothing in Schedule 3

("Performance Management & Governance") limits any rights or obligations of the parties under this Contract, including the right of icare to exercise its powers under clauses 53 and 59. The Claims Service Provider acknowledges that icare may commence action to manage the Claims Service Provider's performance at any time.

54. Force Majeure

54.1 Force Majeure

A party will not be liable for any failure or delay:

(a) in the case of the Claims Service Provider, in the performance or discharge of its obligations under this Contract; and

(b) in the case of icare, in the performance or discharge of its obligations under this Contract,

to the extent that such failure or delay is caused, directly or indirectly, by a Force Majeure Event.

54.2 Fees

icare is not liable to pay any Remuneration to the Claims Service Provider in respect of any period during which the Claims Service Provider has failed to perform any Services due to a Force Majeure Event.

54.3 No application if caused or contributed to by Party seeking to rely on event

This clause 54 does not apply to the extent that any Force Majeure Event is caused or contributed to by a breach of this Contract by the party claiming the Force Majeure Event.

54.4 Notice

A party whose performance or discharge of its obligations referred to in clause 54.1 is affected by a Force Majeure Event must immediately:

(a) notify the other party; and

(b) describe in a reasonable level of detail the nature of the Force Majeure Event, its likely effect on that non-performing party's performance or discharge of its obligations under this Contract, and which Services or obligations can continue to be performed.

54.5 Duty to mitigate

On the occurrence of a Force Majeure Event, the non-performing party must use every effort to continue or resume performance or observance whenever and to whatever extent possible without delay, including by means of alternate sources, work-around or other means.

54.6 Termination by icare

The Claims Service Provider agrees that icare may terminate this Contract by notice to the Claims Service Provider if any Force Majeure Event has the result that the Claims Service

Provider fails to be able to provide complete normal operational capacity and meet its obligations under this Contract within ten Business Days of the Force Majeure Event.

54.7 Pandemic Risk Management Plan

(a) A pandemic or epidemic will not constitute a Force Majeure Event for the purposes of this Contract.

(b) In the event of a current or future pandemic or epidemic, the Claims Service Provider must:

(i) comply with the Pandemic Risk Management Plan agreed by the parties in accordance with this Contract; and

(ii) otherwise undertake all reasonable steps to mitigate the impact on its ability to meet the requirements under this Contract.

(c) The Claims Service Provider will no later than ten Business Days following the Commencement Date, provide a draft pandemic risk management plan (**Draft Pandemic Risk Management Plan**) that sets out the operational processes the Claims Service Provider will undertake (including via the Claims Service Provider's Subcontractors) in respect of its supply of the Services, and which includes details of the disaster recovery procedures that the Claims Service Provider and its Subcontractors have in place to mitigate the impact of any current or future pandemics or epidemics on the Claims Service Provider meeting its obligations under this Contract. icare will provide feedback on the Draft Pandemic Risk Management Plan by no later than ten Business Days following receipt of the Draft Pandemic Risk Management Plan. The Claims Service Provider will finalise the Draft Pandemic Risk Management Plan incorporating icare's feedback (**Pandemic Risk Management Plan**) and provide a copy to icare by no later than ten Business Days following receipt of the Claims Service Provider's feedback on the Draft Pandemic Risk Management Plan.

55. Information security

55.1 Ownership of Records

The Claims Service Provider acknowledges section 154K of the 1987 Act on Records and agrees that it will securely protect and separate icare's Data from any other data of either the Claims Service Provider or any third-party data.

55.2 Use of Records

The Claims Service Provider must not (and must ensure that its Personnel do not):

(a) use Records held by the Claims Service Provider, or which the Claims Service Provider has access to, other than for the purposes of fulfilling its obligations under this Contract;

(b) allow any person, unless authorised by icare or by this Contract, to access or use Records;

(c) purport to sell, let for hire, assign rights in or otherwise dispose of Records;

(d) purport to commercially exploit Records (or allow any Subcontractor or Subcontractor Personnel to do so); or

(e) alter Records in any way, other than in providing the Services as required under this Contract.

55.3 Access to Records from outside Australia

The Claims Service Provider must not, and must ensure that the Claims Service Provider's Personnel do not:

(a) take, transfer or transmit Data or Records or allow Data or Records to be taken, transferred, transmitted or accessed outside of Australia; or

(b) take, transfer or transmit Health Information or allow Health Information to be taken, transferred, transmitted or accessed outside of NSW,

without icare's prior written approval (and provided the Claims Service Provider complies with all conditions of such approval) or in accordance with an Approved Offshore Location Proposal.

55.4 Information security requirements

(a) The Claims Service Provider must establish and maintain the following for the Term:

(i) a formalised Information Security Policy which is reviewed by icare at planned intervals or whenever material changes are made to the policy;

(ii) a formalised Information Security Plan and designated individual responsible for managing information security; and

(iii) a formalised Incident Management Plan for monitoring, reporting and resolving security incidents.

(b) The Claims Service Provider must establish, maintain, enforce and continuously improve safeguards and security procedures against the destruction, unauthorised disclosure, unauthorised access to, loss or alteration of any information, Data and Records in the possession or control of the Claims Service Provider that:

(i) are set out in the Contract, including those contained within the icare Policies described in clauses 23.2(c)(iv) – 23.2(c)(vii);

(ii) are consistent with and are no less rigorous than those referred to in Schedule 8 (“Information Security and Management”), or as otherwise required by icare from time to time;

(iii) are no less rigorous than the safeguards that are consistent with Best Industry Practice; and

(iv) comply with all Laws applicable to the Claims Service Provider’s use and custody of such items and any procedures specified by icare concerning Data security.

(c) icare may from time to time notify the Claims Service Provider advising of a new, or updated data security requirements and requiring the Claims Service Provider to comply with the new, or updated data security requirement. A notice issued under

this clause 55.4(c) will be treated as a Direction issued under clause 39.1(a) and will be subject to clause 39. Except as contemplated in Section J- Directions and Change Management of this Contract, in no circumstances will icare be required to pay any fee or compensation to the Claims Service Provider in relation to the implementation of any notice issued under this clause 55.4(c).

(d) The Claims Service Provider must implement an identity access management system to ensure that only Personnel with a need to know have access to icare's Data.

(e) The Claims Service Provider must implement and operate appropriate backup procedures, to ensure that icare has unhindered, immediate and independent access to the items set out in clause 55.4(b) at all times during the Term.

(f) The Claims Service Provider will ensure that all Data is maintained in a form such that it is retrievable, readable and understandable for the period defined by icare and will comply with applicable Laws and Regulatory Guidance.

(g) All security information provided by the Claims Service Provider will be evaluated by icare's IT Security team and may require supporting evidence and further clarifications.

55.5 Information security certification and testing

(a) The Claims Service Provider must obtain and maintain ISO 27001 certification throughout the Term, the scope of which must, without limiting clause 55.5(b), include all Services provided to icare and all Personnel, systems and locations used to provide them and cannot be cancelled or modified to reduce the scope of the certification or to reduce security controls without icare's prior Approval. As part of the ISO 27001 certification, Claims Service Provider Personnel providing services to icare are required to have undergone information security training.

(b) The Claims Service Provider must ensure that in respect of any Claims Service Provider Personnel who has access to icare's Data:

(i) if the Personnel is an organisation, the organisation, or the team within the organisation which provides Services or supports the Claims Service Provider in its performance of this Contract, is ISO 27001 certified; or

(ii) if the Personnel is an individual, the individual is part of an organisation that is ISO 27001 certified and has access consistent with their organisation's ISO 27001 certificate,

and adheres to icare's information security policies and standards or other information security requirements notified from time to time by icare to the Claims Service Provider.

(c) The Claims Service Provider will provide evidence of ISO 27001 certification, audits and any applicable remedial reports on an annual basis or as reasonably required by icare.

(d) The Claims Service Provider must perform security testing prior to any major information technology release as well as annual security testing of all systems that store, process or transmit icare's Data. The security testing report must be provided

to icare upon request. icare may consider acceptance of an executive summary or attestation report in situations where the original security testing report cannot be provided.

55.6 Information security incidents

(a) In the event of a Data breach or a security incident impacting the Services, the Claims Service Provider must ensure that icare is notified immediately, and in any event, within 24 hours, following the breach or incident.

(b) The Claims Service Provider must notify icare immediately and comply with all reasonable requirements of icare should it becomes aware of the contravention of any Data security requirement.

55.7 Return of Data

The Claims Service Provider must return any of icare's Data in its possession or control to icare promptly on termination or expiration of this Contract or on request by icare at any time. If and when required to do so, the Claims Service Provider must take such reasonable steps as icare requires to ensure accurate deletion of any of icare's Data from the Claims Service Provider's systems, except to the extent the Claims Service Provider must retain icare's Data (or part thereof) to comply with applicable Laws and Regulatory Guidance.

55.8 Subcontracts

The Claims Service Provider must ensure that any contract it enters with a Subcontractor or Service Company under this Contract contains provisions to ensure that the Subcontractor or Service Company has the same awareness and obligations as the Claims Service Provider has under clauses 55.1 to 55.8, including this requirement in relation to subcontracts.

56. Operational risk management

56.1 Business Continuity and Disaster Recovery Planning

(a) The Claims Service Provider must develop, implement, comply with, maintain, test and execute a Business Continuity Plan throughout the Term that is specific to the Services it provides under this Contract. At a minimum, the Business Continuity Plan must describe how the Claims Service Provider will:

(i) establish whether a Fault or disaster has occurred;

(ii) recommence payments to Workers (if stopped) within four Business Days of a Fault or disaster;

(iii) provide the Services following a Fault or disaster;

(iv) assess, minimise and communicate any Data loss; and

(v) keep (and, if necessary, recover) any Records.

(b) The Claims Service Provider must conduct annual business continuity and disaster recovery testing and report to icare on the results of those tests in accordance with Attachment 3.05 ("Reports Matrix").

(c) The Claims Service Provider must support any icare business continuity and disaster recovery plans that icare provides to the Claims Service Provider, and execute those plans.

(d) The Claims Service Provider's Business Continuity Plan must be updated by the Claims Service Provider at least annually.

(e) The Claims Service Provider must provide icare with its initial Business Continuity Plan within 10 Business Days of a request by icare and updated versions of the Business Continuity Plan in accordance with Attachment 3.05 ("Reports Matrix"). To the extent necessary to comply with Law, the Claims Service Provider may redact Personal Information from the Business Continuity Plan that is provided to icare.

(f) The Claims Service Provider will be responsible for the following matters:

(i) any fees charged by third party business continuity or disaster recovery suppliers in relation to the Business Continuity Plan; and

(ii) any other costs, charges, fees or expenses relating to business continuity and disaster recovery including due to the requirements for any upgrade, supplement, modification or replacement in relation to any Equipment, systems, data or processes used by the Claims Service Provider to provide the Services.

56.2 Risk management, Fraud identification and information security

(a) The Claims Service Provider must:

(i) prepare, implement, test and execute risk management policies, the Fraud Risk Management Model and information security management in a form and manner which is effective and complies with the requirements of this Contract; and

(ii) comply with any obligations set out in Schedule 1 (Customer Engagement & Claims Management Services) relating to prevention, identification and management of Fraud.

(b) The Claims Service Provider must conduct annual testing of risk management policies, the Fraud Risk Management Model and information security management and report to icare on the results of those tests.

(c) Without limiting the Claims Service Provider's obligations to prevent Fraud against the Scheme, the Claims Service Provider must support and implement any plans that icare provides to the Claims Service Provider that relate to risk management, Fraud identification or information security from time to time.

(d) The Claims Service Provider will be responsible for the following matters:

(i) any fees charged by third party suppliers in relation to the preparation, implementation, maintenance or testing of risk management policies, the Fraud Risk Management Model and information security management; and

(ii) any other costs, charges, fees or expenses relating to risk management and Fraud identification and information security including, due to the requirement for any upgrade, supplement, modification or replacement in

relation to any Equipment, systems, data or processes used by the Claims Service Provider to provide the Services.

56.3 Requirement to Comply

The Claims Service Provider must at all times have in place and comply with and be responsible for:

(a) the Business Continuity Plan;

(b) the risk management policies;

(c) the Fraud Risk Management Model; and

(d) the information security policies,

referred to in this Contract, and ensure such policies and models are current and effective at all times throughout the Term.

56.4 Rectification

(a) As soon as the Claims Service Provider becomes aware, or is notified by icare, of an error, defect, problem or failure with the Services ("**Fault**"), the Claims Service Provider must:

(i) if icare is not already aware of the details of the Fault, notify icare of the nature and likely impact of the Fault;

(ii) commence rectification and resolve the Fault in accordance with the Business Continuity Plan; and

(iii) regularly report to icare on the status of the diagnosis and rectification of the Fault in accordance with the Business Continuity Plan.

(b) Notwithstanding any other provision of this Contract, the Claims Service Provider must ensure that:

(i) payments to Workers recommence within four (4) Business Days of a Fault; and

(ii) the Services are resumed in full within 15 Business Days of a Fault.

(c) If the Claims Service Provider does not meet the requirements of either clauses 56.4(b)(i) or 56.4(b)(ii), icare may immediately terminate this Contract for cause under clause 59.2 and pursue all remedies available to it under this Contract or at Law for the Claims Service Provider's material breach of this Contract.

56.5 Declarations

On or before 31 July in each Year, the Claims Service Provider must provide to icare a declaration, in the form of Schedule 6 ("Claims Service Provider Declaration"), signed by:

(a) the Chief Financial Officer of the Claims Service Provider; or

(b) another senior executive in the Claims Service Provider Group, provided that icare agreed to that executive signing the declaration.

SECTION M - Dispute Resolution

57. Contract Disputes

57.1 Resolution of Contract Disputes

The parties must attempt to settle any Contract Dispute in relation to this Contract, in accordance with the procedure set out in this clause 57 before resorting to court proceedings or other dispute resolution process.

57.2 Dispute resolution process

This clause outlines the process the parties must follow in the event of a Contract Dispute.

(a) If icare or the Claims Service Provider determines (acting reasonably) that there is a Contract Dispute, then:

(i) the party raising the Contract Dispute must provide a notice (**Dispute Notice**):

(A) in the case of icare providing the notice, to the Claims Service Provider Partnering and Performance Manager; and

(B) in the case of the Claims Service Provider providing the notice, to the icare Partnering and Performance Manager; and

(ii) The icare Partnering and Performance Manager and the Claims Service Provider Partnering and Performance Manager must meet within five Business Days from provision of the Dispute Notice (or such other date as agreed) to attempt to resolve the Contract Dispute.

(b) If the icare Partnering and Performance Manager and the Claims Service Provider Partnering and Performance Manager do not resolve the Contract Dispute within ten Business Days of provision of a Dispute Notice (or such other date as agreed) then Authorised Representatives of the parties must meet within ten Business Days (or such other date as agreed) to attempt to resolve the Contract Dispute.

(c) No less than two Business Days prior to the Authorised Representatives meeting (or such other date as agreed), each party must provide the other's Authorised Representative with a written submission of its view of the Contract Dispute of no more than five pages, setting out the nature of the Contract Dispute, the alleged cause and preferred solutions.

(d) If the Authorised Representatives have not resolved the Contract Dispute within ten Business Days of their first meeting (or such other date as agreed), it will be referred for attempted resolution to:

(i) the Group Executive, Workers Compensation of icare; and

(ii) the Chief Executive Officer of the Claims Service Provider, or their nominee with authority to settle the Contract Dispute.

(e) If there has been no resolution of the Contract Dispute by the Group Executive, Workers Compensation and Chief Executive Officer within ten Business Days (or such other date as agreed) of the Contract Dispute being referred to them under this clause, the parties may agree to mediation or another form of alternative

dispute resolution such as expert determination or arbitration, but if no such agreement exists, either party may pursue court proceedings or any other process available at Law.

57.3 Obligations continue

The Claims Service Provider must continue to perform its obligations under this Contract while a Contract Dispute is being dealt with, in accordance with this clause 57.

57.4 Urgent interlocutory relief and termination

Nothing in this clause 57 will prevent either party from seeking urgent interlocutory (including injunctive) relief or from exercising any right to terminate this Contract.

57.5 Meetings

Any meeting under this clause 57 can take place in person, by telephone, video conference or otherwise as agreed by the parties in writing.

58. Disputes with Third Parties

58.1 Management of Third Party Disputes

Subject to clauses 58.3 and 58.4, the Claims Service Provider may, without the prior Approval of icare, act on behalf of icare in the event of a Third Party Dispute where the Demand arises out of or in connection with the Claims Service Provider performing its obligations under this Contract as agent for icare. For the avoidance of doubt, this clause 58.1 only applies to circumstances where the Claims Service Provider is being pursued as agent for icare, and not where the Claims Service Provider is being pursued in its own name, for example, by a Subcontractor. The Claims Service Provider will keep icare fully informed of all material developments in relation to the Third Party Dispute.

58.2 Legal and other costs incurred by the Claims Service Provider

The Claims Service Provider may incur legal costs, disbursements and third party costs associated with the Third Party Dispute without prior Approval up to an amount of $25,000 (excluding GST) per matter, or series of related matters. Thereafter, the Claims Service Provider must obtain icare's Approval for further costs, disbursements and third party costs associated with the Third Party Dispute.

58.3 Legal proceedings require Approval of icare

The Claims Service Provider will seek the Approval of icare prior to instituting or responding to legal proceedings (including issuing a statement of claim or filing a defence) on behalf of icare, subject to any conditions provided (if any) with such Approval, in relation to:

(a) privacy or Intellectual Property Rights;

(b) Confidential Information;

(c) Third Party Service Providers;

(d) claims of any nature arising in connection with the GIPA Act;

(e) any Demand which could have a material effect on the Workers Compensation Scheme Principles or would become a precedent or cause for subsequent Claims arising from any Policy;

(f) any Demand which could have a material adverse effect on the brand or reputation of icare; or

(g) any Demand (other than a Demand that arises from a Policy) from a third party which claims damages against icare in excess of $50,000.

58.4 icare may issue directions or guidelines

(a) icare may give notices of its requirements and issue guidelines to the Claims Service Provider regarding the conduct or settlement of any Third Party Dispute, including any legal proceedings pursuant to clause 58.3.

(b) Without limitation, for the purposes of clause 58.4(a) icare may require the Claims Service Provider to change its legal representation or seek a reasonable settlement of the Third Party Dispute or allow icare to take over the conduct of the legal proceedings.

(c) Nothing in this clause 58.4 shall require the Claims Service Provider to take any step in the conduct or settlement of a Third Party Dispute that may cause it, or its solicitors, to breach obligations to a Court of law.

58.5 Indemnity by icare

icare will indemnify the Claims Service Provider for all damages (whether finally awarded or agreed through any form of settlement), legal costs, disbursements and third party costs (but not any internal costs of the Claims Service Provider) associated with the legal proceedings under clause 58.3 provided that:

(a) if this Contract requires the Claims Service Provider to obtain icare's Approval, that Approval has been sought;

(b) the Claims Service Provider has complied with any notices or guidelines issued by icare in accordance with clause 58.4;

(c) the Claims Service Provider has met the obligations in this Contract that are in any way connected to the indemnity;

(d) the Claims Service Provider has acted within the authority set out in this Contract; and

(e) the provisions of this Contract do not provide otherwise.

58.6 Compliance with policies

The Claims Service Provider must comply, and must ensure that any Third Party Service Providers that are appointed by the Claims Service Provider (where the appointment is in the Claims Service Provider's capacity as agent of icare), comply (or if debt recovery is done by the Claims Service Provider's employees or the Third Party Service Provider's Personnel, then they must comply) with the policies relating to the conduct of litigation, as set out in Schedule 1 ("Customer Engagement & Claims Management Services"). This includes, but is not limited to, the model litigant policy.

58.7 Fund Loss

The Claims Service Provider agrees that:

(a) subject to the dispute resolution provisions of this Contract, icare is entitled to recover on behalf of the Relevant Fund any Fund Loss suffered as a result of an act or omission of the Claims Service Provider or its Personnel in connection with this Contract recoverable at all as if it were a loss suffered by icare;

(b) it will not, in any legal proceedings referred to in clause 58.7(a) above, raise as a defence or otherwise allege that icare is not entitled to bring the legal proceedings or recover the Fund Loss claimed in the legal proceedings on the basis that the Fund Losses were not suffered by icare; and

(c) this clause may be pleaded in bar to any defence raised by the Claims Service Provider in breach of paragraph 58.7(b).

For the avoidance of doubt, clause 58.7 does not permit any double recovery of any Fund Loss by icare and the Relevant Fund.

Part 7 How we work together to manage exit

Simplified outline of this Part:

This Part 7 contains:

- Section N – Termination; and
- Section O – Disengagement.

Section N sets out provisions relating to each party's rights to terminate the Contract, along with the consequences of termination.

Section O sets out the framework governing Disengagement, including provisions on the development of a Disengagement Plan to be approved by icare that sets out the detail of the Claims Service Provider's Disengagement Services.

SECTION N - Termination

59. Termination

59.1 Termination for convenience

(a) icare may immediately terminate this Contract for convenience by giving not less than three months' notice to the Claims Service Provider.

(b) If icare terminates this Contract under clause 59.1(a), then:

(i) icare will pay to the Claims Service Provider

(A) any Fees owing the Claims Service Provider for the terminated Services provided up to the effective date of termination; and

(B) the Termination for Convenience Charge; and

(ii) the payment of the Termination for Convenience Charge by icare will be the Claims Service Provider's sole and exclusive remedy in respect of any losses arising out of or in connection with that termination.

(c) If a purported termination for cause by icare is determined not to be a valid termination for cause, then that termination will be deemed to be a termination for convenience under clause 59.1(a).

59.2 Termination for cause

icare may immediately terminate this Contract by notice to the Claims Service Provider:

(a) where the Claims Service Provider makes any statement, provides any information, makes any representation, or provides material in response to a request which is false, untrue, or incorrect in a way which in the reasonable opinion of icare materially affects this Contract;

(b) where:

(i) APRA suspends or withdraws any authorisation or licence held by the Claims Service Provider or any Key Input Provider or any of their Related Bodies Corporate or APRA or the responsible minister appoints any investigator to or makes any order relating to a dealing in insurance policies or assets of the Claims Service Provider or any Key Input Provider or APRA commences proceedings against any of their Related Bodies Corporate alleging breach of an enforceable undertaking with APRA;

(ii) a court appoints a judicial manager to the Claims Service Provider or any Key Input Provider or any of their Related Bodies Corporate under Part VB of the *Insurance Act 1973* (Cth);

(iii) the Independent Commission Against Corruption makes finding of corrupt conduct by, or recommends prosecution or disciplinary action in relation to the Claims Service Provider, any Key Input Provider or their Related Bodies Corporate or any of their directors or officers; or

(iv) the police or SIRA (in its role as regulator) or other investigative body brings legal proceedings against the Claims Service Provider, any Key Input Provider or their Related Bodies Corporate alleging corrupt conduct or breach of any Laws;

(c) where the Claims Service Provider was or is a party to a Claims Management Agreement other than the Contract (an "**Other Claims Management Agreement**"):

(i) the Claims Service Provider breaches a material provision of an Other Claims Management Agreement that is not capable of remedy; or

(ii) icare becomes aware of a breach of an Other Claims Management Agreement by the Claims Service Provider which, if known prior to the expiry or termination of that Other Claims Management Agreement, would have entitled the applicable counterparty to terminate that agreement for cause;

(d) where the Claims Service Provider commits a material breach of the Contract that is not capable of remedy;

(e) where the Claims Service Provider commits a breach of the Contract that is capable of remedy and the Claims Service Provider does not remedy the breach in accordance with the terms of and within the period set out in any Remediation Plan issued or Approved in accordance with clause 53.2;

(f) where the Claims Service Provider commits a breach of any of its obligations in any of the following clauses (whether material or not):

(i) the scope of its appointment as set out in this Contract;

(ii) clause 26 (Performance Guarantee);

(iii) clause 27 (Financial Security);

(iv) clauses 33.1(Ownership of Records and Foreground Material), 33.2 (Claims Service Provider licence to icare) and 33.4 (Intellectual Property Rights licences to Claims Service Provider);

(v) clauses 47.1(a) – 47.1(k) (General warranties);

(vi) clause 47.5 (Requirements and condition of disclosure);

(vii) clause 51 (Insurance to be maintained by the Claims Service Provider);

(viii) clause 62.12 (Claims Service Provider must not assign without Approval);

(ix) clause 62.13 (No Assignment of subcontract with Key Input Provider); or

(x) where the terms of the Contract expressly permits icare to terminate the Contract;

(g) where the Claims Service Provider or the Guarantor is Insolvent;

(h) if, in icare's view, a Conflict exists for the Claims Service Provider which in icare's absolute opinion prevents the proper performance of the Contract;

(i) there is a Change of Control, other than an Authorised Change of Control, of the Claims Service Provider or the Guarantor that has not been Approved by icare; or

(j) the Claims Service Provider represents or communicates to icare, or icare forms the opinion, on reasonable grounds, that the Claims Service Provider is unable or unwilling substantially to fulfil the Claims Service Provider's duties under this Contract.

59.3 Powers following termination for cause

If icare terminates this Contract for cause under clause 59.2, icare may do any or all of the following:

(a) enter into an agreement with any other person to complete the provision of the Services;

(b) deduct any loss or damages (which will be as ascertained and certified by icare, acting reasonably) from any money due, or which may become due, to the Claims Service Provider (arising out of or in connection with this Contract or otherwise) from the Financial Security, or otherwise set-off the amount in accordance with clause 21; and/or

(c) recover in an appropriate Court the balance of any outstanding loss or damage or Interim Payment as a debt due and payable by the Claims Service Provider to icare.

59.4 Right for Claims Service Provider to terminate

(a) Subject to clauses 59.4(b) and 59.4(c), the Claims Service Provider expressly waives any rights it has to terminate this Contract.

(b) If:

(i) icare has not paid the Claims Service Provider's Remuneration within 60 Business Days after the due date for the payment and has not by that time notified the Claims Service Provider that it is withholding payment of Remuneration in accordance with clause 13.2;

(ii) the amount not paid exceeds 50% of the Annual Base Fee;

(iii) the Claims Service Provider has issued a notice to icare advising that:

(A) payment is overdue; and

(B) the Claims Service Provider will terminate the Contract if payment is not made within 40 Business Days of icare receiving that notice; and

(iv) having received a notice under subparagraph 59.4(b)(iii), icare fails to pay the Remuneration within 40 Business Days of receipt of that notice,

then the Claims Service Provider may terminate this Contract.

(c) The Claims Service Provider may terminate this Contract for any reason by giving at least 12 months' notice to icare. Where the Claims Service Provider terminates under this clause 59.4(c), the Claims Service Provider agrees that it will not be entitled to any associated costs, losses or other Fees relating to the termination, including costs associated with Disengagement Services, but will be entitled to payment for Services performed in accordance with this Contract in accordance with clause 13.1 up to the effective termination date.

59.5 Termination consequences - general

(a) Termination of this Contract by icare will not release the Claims Service Provider from liability in respect of any breach or non-performance of any obligation by the Claims Service Provider under this Contract.

(b) Any termination of this Contract is without prejudice to any accrued rights or remedies of either party.

(c) The rights, remedies, powers, entitlements or privileges of icare in this clause 59 and in this Contract are cumulative with, without prejudice to, and not exclusive of, any other right, remedy, power, entitlement or privilege granted or given anywhere in this Contract or the Law (unless expressly stated otherwise in clause 59.2).

59.6 Termination consequences – delivery of Material

On the expiration or earlier termination of this Contract or on such earlier date as may be specified by icare, the Claims Service Provider must deliver to icare (or otherwise deal with as directed by icare) a complete copy of:

(a) any icare Material in its possession; and

(b) any Deliverable that as at the termination or expiry date (as applicable) has not yet been completed.

59.7 Termination consequences – transfer of Personnel

On the expiration or earlier termination of this Contract, the Claims Service Provider agrees to act reasonably and co-operate with icare to facilitate the making of offers of employment by Other Claims Service Providers to Personnel of the Claims Service Provider who will not, or are unlikely to, be redeployed within the business of the Claims Service Provider and its Related Bodies Corporate.

SECTION O - Disengagement

60. Disengagement Services

60.1 Obligation to Provide Disengagement Services

(a) The Claims Service Provider must commence providing the Disengagement Services immediately on such date:

(i) as agreed by the parties; or

(ii) as icare may specify in a notice to the Claims Service Provider, provided that such date must not be more than 6 months prior to the date of:

(A) termination of the Contract;

(B) the expiry of the Initial Contract Term where an extension has not been exercised in accordance with clause 4.3(a); or

(C) the expiry of any Extension Period exercised in accordance with clause 4.3(a) where a further extension has not been exercised or does not apply,

as applicable.

(b) The Claims Service Provider must provide the Disengagement Services for the duration of the Disengagement Period.

(c) The Claims Service Provider must continue to provide the Services and to achieve all Performance Measures in each Reporting Period during the Disengagement Period, except as directed by icare.

60.2 Requirements for Disengagement Services

The Claims Service Provider must, when performing the Disengagement Services:

(a) ensure that there is minimal disruption to Workers, Employers, Third Party Service Providers and other stakeholders to the fullest extent possible;

(b) ensure that there is minimal interruption to the provision of Services;

(c) cooperate as reasonably necessary with icare or its nominee;

(d) perform the Disengagement Services in accordance with the Disengagement Plan or as directed by icare;

(e) deliver all Deliverables described in the Disengagement Plan by the relevant Milestone; and

(f) comply with any requirement Directed by icare where icare believes that the requirement is necessary or desirable to:

(i) minimise disruption to Workers, Employers, Third Party Service Providers and other stakeholders to the fullest extent possible; or

(ii) ensure all Services continue to operate without interruption or adverse effect; and

(g) otherwise in accordance with the requirements of this Contract.

60.3 Disengagement Plan

(a) The Claims Service Provider must, within 20 days of receiving notice from icare, prepare a Draft Disengagement Plan:

(i) in accordance with any Disengagement Plan guide provided by icare from time to time;

(ii) that is consistent with Schedule 7 ("Claims File Transfer");

(iii) that is consistent with icare's Data and record management requirements including as set out in Schedule 8 ("Information Security and Management");

(iv) that is consistent with the following:

(A) the Claims Service Provider will not be entitled to charge, and icare will not be required to pay, the Claims Service Provider for the provision of Disengagement Services or performance of the Disengagement Plan, except in limited circumstances specifically agreed in the Disengagement Plan;

(B) except to the extent covered by the Termination for Convenience Charge (if applicable), icare will accept no liability for losses arising out of or in connection with the termination or expiry of the Contract, including any payments or other costs for which the Claims Service Provider is liable arising out of or in connection with redundancies of, or termination of contracts, with Claims Service Provider Personnel; and

(C) the Disengagement Plan will address the transfer to icare of custody of all icare Material (including processes for orderly migration and management of that icare Material), and no icare Material in the custody or control of the Claims Service Provider or its Personnel may be destroyed without icare's approval; and

(v) in accordance with any other requirements of icare.

(b) icare may either:

(i) Approve the Draft Disengagement Plan, in which case the Draft Disengagement Plan will become the Disengagement Plan; or

(ii) acting reasonably, request amendments to the Draft Disengagement Plan, in which case the Claims Service Provider must make the amendments and resubmit the Draft Disengagement Plan for icare's Approval, within 20 days of receiving the request. If Approved by icare, the amended Draft Disengagement Plan will become the Disengagement Plan.

(c) The Disengagement Plan Approved by icare must be updated by the Claims Service Provider:

(i) annually;

(ii) at any time as required by icare;

(iii) on any occasion when there is a substantial change to:

(A) this Contract; or

(B) the volume of Claims or Services managed by the Claims Service Provider;

(iv) six months prior to the end of the Initial Contract Term and any extension exercised in accordance with clause 4.3(a); and

(v) if the Contract is terminated in accordance with clause 59.1,

and must at all times meet the requirements as reasonably required by icare.

60.4 Appointment of Personnel to provide Disengagement Services

During the Disengagement Period icare may designate which of the Claims Service Provider's Personnel must provide the Services, and the Claims Service Provider must not remove those Personnel from providing the Services without icare's prior Approval. The Claims Service Provider is not in breach of this clause 60.4 if a designated individual is an employee of the Claims Service Provider or any Service Company and the individual leaves the employment of the Claims Service Provider or any Service Company (provided the individual is not then employed, or engaged in any way, by any member of the Claims Service Provider Group).

60.5 Obligations on Claims Service Provider on disengagement

Without limiting any of the Claims Service Provider's obligations under the Disengagement Plan, the Claims Service Provider must within five Business Days of receipt of a requirement to do so or by the end of the Disengagement Period (whichever is sooner):

(a) procure, at its cost, the novation of those Subcontractor contracts, to icare or its nominee, as directed by icare. The Claims Service Provider is responsible for any costs associated with the novation of the Subcontractor contracts, and icare is responsible for the on-going operational fees and charges for the goods or services that are the subject matter of the Subcontractor contracts;

(b) deliver to icare or its nominee a copy of all of icare's Confidential Information in the custody or control of the Claims Service Provider, Subcontractor, Third Party Services Provider or Service Company;

(c) deliver to icare or its nominee a copy of Materials containing the Intellectual Property Rights used in connection with the Services which icare either owns or is entitled to have assigned to it under clause 33; and

(d) deliver to icare, or its nominee, all of icare's Confidential Information, the Records and any ancillary materials, including file jackets and bindings that icare believes are necessary or desirable to enable the Services or goods or services similar to the Services to be provided by icare or its nominees in a manner which minimises the disruption, to the fullest extent possible, to Workers, Employers, Third Party Service Providers and other stakeholders caused by the disengagement of the Services.

60.6 Delivery of Material in Electronic Form

To the extent that the items in clauses 60.5(b), 60.5(c) or 60.5(d) are stored in electronic form, the Claims Service Provider must deliver them in an electronic form which is readily accessible to icare. If requested by icare the Claims Service Provider must provide icare or

its nominee access to or use of the Claims Service Provider Material as required by clause 33 or use of or access to any Equipment reasonably required to run or exercise its rights of access or use during the Term and for a period of up to six months after the Term as may be required by icare to enable icare to:

(a) exercise its rights under clause 33;

(b) store, access and view and reproduce any data incorporated in any item in clauses 60.5(c) or 60.5(d) without technical restriction; and

(c) provide the Services or goods or services similar to the Services in a manner which minimises any disruption, to the fullest extent possible to Workers, Employers, Third Party Service Providers and other stakeholders caused by the disengagement of the Services.

Part 8 Housekeeping

Simplified outline of this Part:

This Part 8 contains Section P – General.

Section P sets out general provisions governing the Contract as a whole, including provisions relating to notices, consents and approvals, variation, assignment and governing law, the dictionary and facility for other Government Agencies to engage the Claims Service Provider on equivalent terms.

SECTION P - General

61. Notices

61.1 Communication protocol

In accordance with Schedule 3 ("Performance Management & Governance"), the parties acknowledge and agree that correspondence of an operational nature between the parties will primarily occur via email to and from the email addresses designated from time to time by the Claims Service Provider and icare.

61.2 Giving of Notices

(a) A notice, Approval, Direction, consent, or other communication under this Contract must be in writing and must be:

(i) left at the property address of the addressee set out at item 12 of the Contract Details;

(ii) sent by prepaid ordinary post (airmail if posted to or from a place outside Australia) to the property address of the addressee set out in the Contract Details;

(iii) hand delivered to the relevant person identified in the Contract Details; or

(iv) sent by email to the email address of the addressee set out in the Contract Details unless otherwise advised by icare in writing.

(b) Unless a later time is specified in it or in this Contract, a notice, Approval, Direction, consent, or other communication takes effect from the time it is received.

(c) A communication under this Contract to which this clause 61.2 and clause 61.3 apply includes a communication between the parties or their permitted representatives that:

(i) relates to an actual or alleged breach of this Contract;

(ii) contains content of a regulatory nature; or

(iii) contains information relating to Remuneration (including associated information regarding levels of performance against the Performance Measures).

61.3 Receipt of notices

A notice, Approval, Direction, consent, or other communication under this Contract is taken to be received:

(a) if left at the property address, on the 1st Business Day after leaving it;

(b) if posted, on the 2nd (7th if posted to or from a place outside Australia) Business Day after posting;

(c) if sent by email, at the time the email is received by the addressee, unless received after 5.00 pm on a Business Day or on a day which is not a Business Day, in which case it will be taken to be received at 9.00 am the next Business Day; or

(d) if given or served by hand, at the time of delivery, unless the time of delivery is after 5.00 pm on a Business Day or on a day which is not a Business Day, in which case it will be taken to be received at 9.00 am the next Business Day.

61.4 Change of address to be given by notice

A party may notify the other party of a change to the property address, email address or relevant person by notice in accordance with clause 61.3.

62. General

62.1 No exclusivity

The Claims Service Provider agrees that its relationship with icare is not exclusive and at any time during the Term, icare may:

(a) perform services the same as or similar to the Services; or

(b) enter into any arrangements, including agency arrangements, with any third party or Other Claims Service Providers to perform services the same as or similar to the Services.

62.2 Requirement of writing

All consents, Approvals, ratifications, waivers and Directions made under this Contract must be in writing.

62.3 Perfection of rights

The Claims Service Provider must execute all Documents and do all things required, at its cost (unless otherwise agreed), to give effect to the provisions of this Contract (including dealing with Intellectual Property Rights).

62.4 Consents, Approvals or waivers

(a) Any notice, Approval, Direction or waiver to be given by icare under this Contract may be given by a duly authorised officer of icare.

(b) Any Approval given by icare does not release the Claims Service Provider from performing its obligations in accordance with this Contract.

(c) By giving any Approval, consent or waiver, icare does not give any representation or warranty as to any circumstance in connection with the subject matter of the consent, Approval or waiver.

(d) The Claims Service Provider agrees to comply, and ensure that its Related Bodies Corporate comply, with all conditions in any consent, Approval or waiver.

62.5 Discretion in exercising rights

Unless this Contract expressly states otherwise, icare may exercise a right, power or remedy or give or refuse its consent, Approval or a waiver in connection with this document in its absolute discretion (including by imposing conditions).

62.6 Partial exercise of rights

Unless this document expressly states otherwise, if icare does not exercise a right, power or remedy in connection with this document fully or at a given time, it may still exercise it later.

62.7 Variation

Subject to clause 41, a provision of this Contract, or right, power or remedy created under it, may not be varied or waived except in writing signed by both parties. Any variation to this Contract takes effect from the date specified in the deed or understanding or, if no date is specified, the date on which the Parties agree to the variation in writing.

62.8 Non-waiver

No failure or delay by a party in exercising any right, power or remedy under this Contract and no course of dealing or grant by that party of any time or other consideration, will operate as a waiver of a default by the other party. Any waiver of a default of this Contract will not be construed as a waiver of any further breach of the same or any other provision.

62.9 Severability

If any part of this Contract is prohibited, void, voidable, illegal or unenforceable, then that part is severed from this Contract but without affecting the continued operation of the remainder of the Contract. This clause has no effect if the severance alters the basic nature of this document or is contrary to public policy.

62.10 Relationship created by this Contract

The legal relationship created by this Contract is that of principal and limited agent. Nothing contained or implied in this Contract creates a partnership, joint venture or contract of employment.

62.11 Assignment by icare

Notwithstanding any other provision of this Contract, icare may assign or otherwise deal with its rights under this Contract in order to implement any change to the structure, functions or operations of icare or any other Government Agency made by Law and the Claims Service Provider agrees that in such circumstances, it will owe its obligations to the incoming Government Agency rather than to icare. icare must give the Claims Service Provider as much notice of such assignment as is reasonable in the circumstances.

62.12 Claims Service Provider must not assign without Approval

The Claims Service Provider must not assign, novate or transfer the whole or part of this Contract or any payment or other right, benefit or interest under this Contract without the prior Approval of icare.

62.13 No Assignment of subcontract with Key Input Provider

The Claims Service Provider must ensure that those parts of the subcontract between it and any Key Input Provider that relate to the Services or to the Claims Service Provider's duties or obligations under this Contract are not assigned, novated or transferred in whole or part, including any payment or other right, benefit or interest under that subcontract, by the Key Input Provider or icare without obtaining the prior Approval of icare.

62.14 Claims Service Provider must represent itself as agent

In carrying out its obligations under this Contract, the Claims Service Provider must represent itself as an agent of icare in all dealings with Employers and Workers and any other third parties only to the extent of the scope of its agency as set out in this Contract.

62.15 Entire agreement constituted by this Contract

(a) This Contract constitutes the entire agreement and understanding between the parties as to the subject matter of this Contract.

(b) Subject to clause 62.15(c), any prior arrangements, agreements, representations or undertakings as to the subject matter of this Contract are superseded.

(c) The entry into this Contract is not intended to operate as a waiver of any accrued right or obligation of the parties arising prior to the Commencement Date and is not intended to act as a waiver or forgiveness for a breach of any prior agreement between icare and the Claims Service Provider.

62.16 Legal advice and costs

Each party will bear its own costs incurred in relation to the preparation, negotiation and execution of this Contract.

62.17 Stamp duties and taxes

In relation to this Contract and its performance:

(a) all stamp duties (including fines, penalties and interest) that may be payable on or in connection with this Contract and any instrument executed under it must be borne by the Claims Service Provider;

(b) all taxes (except GST which is dealt with in clause 19), duties, charges imposed or levied in Australia or overseas in connection with the performance of this Contract will be borne by the Claims Service Provider; and

(c) the Claims Service Provider must indemnify icare against any Demand incurred or suffered arising from a breach of clauses 62.17(a) and 62.17(b).

62.18 No lien over icare's property

The Claims Service Provider does not have, and must not permit, the creation of any general or particular security interest or other form of encumbrance over icare's property, including icare's Confidential Information and icare Material, whether for the Claims Service Provider's benefit or for the benefit of any third party.

62.19 Counterparts

This Contract may be executed by counterparts by the respective parties, which together will constitute one Contract.

62.20 Governing law

The Law in force in New South Wales governs this Contract. The parties submit to the non-exclusive jurisdiction of the courts of that place.

62.21 Survival

Any provision of this Contract that by its nature survives termination or expiry of the Contract (including in relation to the performance of the Disengagement Services) will survive, including:

(a) clause 13.7 (Remuneration may be recalculated);

(b) clause 19 (GST and other taxes);

(c) clause 26 (Performance Guarantee);

(d) clause 27 (Financial Security);

(e) clause 33 (Intellectual Property Rights);

(f) clause 34 (Confidentiality);

(g) clause 35 (Public Access to Government Information);

(h) clause 36 (Media and Public Relations);

(i) clause 37 (Protection of Personal Information);

(j) clause 46 (Records, inspections and audits);

(k) clause 47.1 (General warranties);

(l) clause 49 (Indemnity);

(m) clause 50 (Limit of Liability);

(n) clause 51 (Insurance to be maintained by the Claims Service Provider);

(o) clause 55 (Information security);

(p) clause 57 (Contract Disputes);

(q) clause 59 (Termination);

(r) clause 60 (Disengagement Services);

(s) clause 61 (Notices);

(t) clause 62 (General);

(u) clause 62.17 (Stamp duties and taxes); and

(v) clause 64 (Dictionary and interpretation).

63. Services to other Government Agencies

63.1 Obligation to provide Services

The Claims Service Provider offers to provide the Services to any Government Agency in accordance with the requirements set out in this clause 63.

63.2 Acceptance

A Government Agency may accept the offer made under clause 63.1 by giving the Claims Service Provider an Instrument of Acceptance.

63.3 Contracting

(a) The terms and conditions of that offer are the same terms and conditions as set out in this Contract, except as modified by the Instrument of Acceptance.

(b) Each Instrument of Acceptance given to the Claims Service Provider in accordance with this Contract will create a separate Contract between the Claims Service Provider and the Government Agency.

64. Dictionary and interpretation

64.1 Dictionary

In this Contract the following terms have the meaning assigned to them below:

1987 Act	the *Workers Compensation Act 1987* (NSW).
1998 Act	the *Workplace Injury Management and Workers Compensation Act 1998* (NSW).
2012 Legislative Reforms	the amendments to the 1987 Act and the 1998 Act effected by the *Workers Compensation Legislation Amendment Act 2012* (NSW) to the extent that they are connected with Benefits, Claims and Policies and related matters.
Aboriginal Participation Plan	the plan of that name developed pursuant to the Aboriginal Procurement Policy and Approved by icare in accordance with clause 25.4(a).
Aboriginal Procurement Policy	the NSW government's policy titled “Aboriginal Procurement Policy” as updated from time to time.
Aboriginal Business	has the meaning given in the Aboriginal Procurement Policy.

Accept	to accept: (a) Transition-In in accordance with clause 5.3; (b) a Claims Files Transfer; (c) a Deliverable under a Statement of Work or Delivery Proposal; (d) Services under a Statement of Work or Delivery Proposal; or (e) any other Milestone. **Accepted**, **Accepting** and **Acceptance** have corresponding meanings.
Acceptance Criteria	the requirements set out in the Transition-In Plan, Disengagement Plan, Claim Files Transfer, Schedules or a Statement of Work which a Deliverable or Services must meet to be Accepted by icare.
Active Claims	the number of Claims active at the end of each six month period. A Claim is deemed active under either of the following conditions: (a) is in the first two months since the date reported (or entered in system); or (b) it is within two months since the last payment on that Claim.
Actual Operating Cost	has the meaning given in Schedule 2.
Adjustments, **Adjustment Events** and **Adjustment Note**	have the meanings given to them in the GST Law.
Affected Customer	has the meaning given in clause 38.3(d)(i).
Amount Incurred	has the meaning given in clause 19.4.
Annual Base Fee	has the meaning given in Schedule 2.
Annual Business Plan	the annual business plan developed and Approved under section 3.3 of Schedule 3 (“Performance Management & Governance”).

Annual Innovation and Strategic Investment Pool	has the meaning given in Schedule 2.
Annual Outcome Fee	has the meaning given in Schedule 2.
Annual Quality Fee	has the meaning given in Schedule 2.
Applicable Calendar Year	has the meaning given in section 3.3 of Schedule 3 ("Performance Management & Governance").
Applicable Standards	the standards specified by icare in the Contract or notified by icare to the Claims Service Provider from time to time, but do not include the Performance Measures.
Approve or **Approval** or **Approved**	written notice from icare signifying that the relevant Milestone, Deliverable or other item that requires icare's approval has completed the formalities for approval.
Approved Auditor	has the meaning given in clause 46.3.
Approved Locations	the locations set out in item 8 the Contract Details (if any) together with all additional locations approved, or as amended, from time to time in accordance with clause 10.
Approved Offshore Location Proposal	a Location Proposal relating to the provision of Services from a Location outside Australia that is Approved by icare under clause 10(d), including any conditions imposed by icare, for so long as the Approval is not withdrawn.
APRA	the Australian Prudential Regulation Authority, or any successor body.
ASIC	the Australian Securities & Investments Commission, or any successor body.
Attachment	each of the attachments to a Schedule of this Contract.
Authorised Representative	either the Claims Service Provider Authorised Representative or icare Authorised Representative.
Authority	a statutory authority, statutory corporation, government or semi-government body.
Authorised Change of Control	(a) a Change of Control of the Claims Service Provider that is part of a solvent internal restructure or amalgamation of the corporate group constituting the

	Claims Service Provider and its Related Bodies Corporate provided that the ultimate parent company continues to control the Claims Service Provider and involves wholly owned subsidiaries of that parent company only; and (b) a Change of Control that amounts to a change in ownership of control of the Claims Service Provider through a public trading of shares.
Australian Standard	an Australian Standard (AS), or an Australian/New Zealand Standard (AN/NZS) published by Standards Australia (Standards Association of Australia).
Banking and Financial Management Services	the Services described in Schedule 5 ("Banking and Financial Management") to be undertaken by the Claims Service Provider, including in relation to banking arrangements, taxation management and financial reporting.
Basic Tariff Premium	has the meaning given in the Workers Compensation Market Practice and Premiums Guidelines issued by SIRA.
Benefits	has the meaning given in the 1987 Act and the 1998 Act and includes payments made to Workers for: (a) compensation payable on death; (b) weekly compensation for income and support; (c) medical, hospital rehabilitation, legal and related expenses; and (d) non-economic loss and property damage. For avoidance of doubt, Benefits includes amounts payable to Third Party Service Providers by icare.
Best Industry Practice	the degree of skill, diligence, prudence and foresight that would reasonably be expected from a professional, reputable, expert, experienced and prudent supplier of claims management services in Australia similar to Services.
Business Continuity Plan or **BCP**	the plan addressing the Claims Service Provider's capability, systems and processes for business continuity and disaster recovery in respect of the Services, that is in place at the Commencement Date, and as updated from time to time.
Business Day	a day on which banks are open for general banking business in New South Wales (not being a Saturday, Sunday or public holiday in that place).

Calendar Day	any day of the week from Monday to Sunday, irrespective of whether or not it is a public holiday.
Calendar Year or **Year**	the period commencing 00:00:00 1 January and ending 23:59:59 31 December.
Case Management	a coordinated approach that integrates both Injury Management and Claims Management to achieve an outcome including treatment, rehabilitation, retraining, liability determination, factual investigation, Claims estimation, and employment management practices, for the purpose of achieving optimum results regarding a timely, safe and durable Return to Work for injured Workers.
Case Manager	a suitably qualified individual responsible for the integration of all aspects of Injury Management and Claims Management.
Certificate of Capacity	a certificate given by a medical practitioner in a form Approved by icare, certifying the Worker's capacity for work.
Change of Control	a change in the Control of a relevant entity after the Commencement Date.
Chargeable Direction	a Direction issued, or deemed to be issued, under clause 39: (a) that is issued other than to: (i) change the Operational Measures in accordance with clause 41.4; (ii) address compliance with any applicable Laws, including the WH&S and Workers Compensation Legislation, or Regulatory Guidance; (iii) address compliance with Best Industry Practice; (iv) address engagement (or cessation of engagement) of Third Party Service Providers, including directions given under clause 28; (v) address provision of and compliance with remediation programs in response to performance failures or other breaches of the Contract; or (vi) address compliance with any other obligation or requirement of this Contract (excluding an obligation or requirement that arises solely by

	virtue of the issuing of the Direction or deemed Direction itself); and (b) the implementation of which the Claims Service Provider can demonstrate to icare's reasonable satisfaction will cause the Claims Service Provider to incur material incremental Direct Costs.
Chief Executive Officer	the Chief Executive Officer of icare, or Chief Executive Officer of the Claims Service Provider respectively (or their delegates) as required by the context in which this term appears.
Claim	includes a claim for compensation or Work Injury Damages that a person has made or is entitled to make under the 1987 Act and the 1998 Act and includes a Long Tail Claim.
Claim Handover	the transferring of a case and all associated files, Records and other necessary information to any individual within the Claims Service Provider.
Claims Experience Standards	has the meaning given to it in section 5 of Schedule 1 ("Customer Engagement & Claims Management Services").
Claims File	includes all material relating to management of a Claim, including but not limited to Records, claim review notes, claims strategy documents, Injury Management Plans, and in any format including but not limited to paper, images, videos and transcripts.
Claims File Transfer	the act of transferring Claims Files between the Claims Service Provider and Other Claims Service Providers when directed to do so by icare within the Claims Technology Platform and in accordance with the Claims File Transfer Requirements.
Claims File Transfer Requirements	the requirements set out in Schedule 7 ("Claims File Transfer").
Claims Incurred	Claims with a date of Injury during the Calendar Year (n).
Claims Management	the effective coordination of all activities associated with the just and economic resolution of an injured Worker's Claim and includes activities associated with determining liability, providing Benefits and processing the Claim.

Claims Management Agreement	an agreement between the Claims Service Provider and icare, the Nominal Insurer or a party on whose behalf icare manages that agreement, relating to agency arrangements or arrangements similar to this Contract in relation to Claims Management.
Claims Management Services	all activities and processes associated with the management and administration of a Workers Compensation Claim under the Workers Compensation Scheme.
Claims Master File	has the meaning given in section 5.1 of Attachment 3.04 (“Internal Controls Framework”).
Claims RACI	the framework under which the Claims Service Provider must manage the Services and consult with icare as required and detailed in Attachment 1.01 (Claims RACI).
Claims Service Provider	has the meaning given in item 1 of the Contract Details, and is a party to this Contract.
Claims Service Provider Group	the Claims Service Provider, Service Company and any Related Body Corporate of the Claims Service Provider or Service Company.
Claims Service Provider Material	any Material in which Intellectual Property Rights are owned by the Claims Service Provider or its Personnel or licensed to the Claims Service Provider or its Personnel by a third party and which is: (a) incorporated within a Deliverable; (b) otherwise provided to, or accessed by, icare in connection with the Contract; or (c) used by the Claims Service Provider or its Personnel to provide Services or Deliverables or perform its obligations under this Contract, but excluding icare Material.
Claims Service Provider Partnering and Performance Manager	the person named as such in item 11 of the Contract Details or such other person as the Claims Service Provider may nominate in writing from time to time who is authorised to represent the Claims Service Provider and who is Approved by icare in accordance with clause 44.
Claims Service Provider Authorised Representative	the person named as such in item 11 of the Contract Details or such other person as the Claims Service Provider may nominate in writing from time to time who is authorised to

	represent the Claims Service Provider and who is Approved by icare in accordance with clause 43.
Claims Service Provider Operational Data	information that relates to, or is created by or for, icare or its Personnel relating to: (a) the operation, facilities, customers, employees, assets, finances, or transactions of icare or its Personnel, or relating to the Scheme; or (b) policies or processes of a Government Agency, but excluding the Records.
Claims Technology Platform	the network of information technology systems owned or licensed by the icare for the management of all Claims, as described in Schedule 9 ("Claims Technology Platform"). The Claims Technology Platform includes systems relating to the following components: (a) policy and claim management; (b) Employer and Worker portals and websites; (c) Employer and Worker service platform including telephony; (d) document management; (e) financial management; (f) data and analytics; (g) platform integrations including to external system; and (h) user access and delegation controls.
Closed Claims	those Claims identified as being closed in the CDR.
Commencement Date	the date specified in item 4 of the Contract Details.
Common Work	has the meaning given in clause 38.3(d)(i).
Commutation	an agreement to commute a liability to a lump sum, within the meaning of Part 3 of the 1987 Act.
Corporation	has the meaning given in the Corporations Act.
Complaints	has the meaning given in icare's Complaints Policy as updated from time to time, and includes complaints received by the Claims Service Provider from an Employer, injured Worker or Third Party Service Provider in relation to the provision of the Services.

Complaints Guidelines	icare's complaints guidelines, as further described at clause 23.2(c)(i) and section 10.1 of Schedule 1 ("Customer Engagement & Claims Management Services").
Complaint Levels	the enterprise complaint categorisations set out in the Complaints Guidelines.
Complaints Policy	icare's complaints policy Document, as further described at clause 23.2(c)(i).
Complex Complaint	a complaint which involves greater depth of investigation of customer circumstances, documents, regulator or process or where multiple contacts with the customer, other teams or senior staff are required to resolve the complaint.
Complex Customer Circumstances Guidelines	icare's complex customer circumstances guidelines, as further described at clause 23.2(c)(iii) and section 10.1 of Schedule 1 ("Customer Engagement & Claims Management Services").
Conduct Risk	the risk that decisions and behaviours lead to detrimental or poor outcomes for Employers and injured Workers.
Confidential Information	(a) any information disclosed by either party to the other, whether before or after the Commencement Date, that: (i) is by its nature confidential; (ii) is designated as confidential; or (iii) the other party knows or ought to know is confidential; but does not include information which: (b) is or becomes public knowledge other than by: (i) breach of the Contract; or (ii) breach of any obligation of confidentiality; or (c) is in the lawful possession of the other party without restriction in relation to disclosure before the date of receipt of the information; or (d) is created independently of the disclosing party's Confidential Information. The terms of this Contract are not confidential, except to the extent set out in the Details as a Commercial-in-confidence term.

	Information about the degree of achievement by the Claims Service Provider of Performance Measures in relation to Claims managed by the Claims Service Provider is not confidential to the Claims Service Provider.
Confidentiality Deed	the confidentiality deed as provided by icare from time to time.
Conflict	any conflict of interest, any risk of conflict of interest and any apparent conflict of interest arising through the Claims Service Provider (or its officers, Personnel), Service Company (or its Personnel) or Related Body Corporate engaging in any activity or obtaining any interest that is likely to conflict with or restrict the Claims Service Provider in performing the Services fairly and independently. Without limiting the meaning of Conflict, the parties acknowledge and agree that the following scenarios represent a Conflict: (a) if the Claims Service Provider, Service Company or Related Body Corporate (or their respective Personnel) receives, or accepts, an offer of a gift or benefit (directly or indirectly) above $50 from a third party involved in the Services (including, to avoid doubt, a Third Party Service Provider), unless accepting the gift or benefit that is: (i) expressly permitted under this Contract; or (ii) Approved in writing by icare; and (b) if the Claims Service Provider fails to pursue a Benefit, remedy or action on behalf of icare, a Worker or Employer, where the pursuit or recovery of that Benefit, remedy or action would cause the Claims Service Provider or a Key Input Provider or Related Body Corporate (or their respective Personnel) to incur a cost or a detriment. For example, a failure to pursue a compulsory third party insurer that is liable for contribution in respect of a Claim when that compulsory third party insurer is a Related Body Corporate of the Claims Service Provider.
Contract	consists of the documents described in clause 3.1 (“Contract parts”).
Contract Details	the part so titled in Section 1 (Contract Details) titled “Contract Details”.
Contract Dispute	any difference between the parties arising under or in connection with this Contract.

Contract Terms	clauses 1 to 65 of this document.
Control	has the meaning given in section 50AA of the Corporations Act.
Corporate Data Repository or **CDR**	the data repositories used by icare as Claims databases which comprise data submitted by the Claims Service Provider and Other Claims Service Providers.
Corporations Act	the *Corporations Act 2001* (Cth).
Customer Experience Measurement Program	the software selected by icare from time to time that is used to measure and report on the customer experience which, as at the Commencement Date, is known as Qualtrics.
Customer Service Model	the systems, processes, practices and values the Claims Service Provider must develop and implement for managing customer service in accordance with Schedule 1 ("Customer Engagement & Claims Management Services").
Data	all Technical Data, reports, test results, analyses, computer programs, computer data bases, diagrams and specifications, working papers, formulae, operating procedures and any other data or information of any kind relating to the Services or this Contract.
Data Migration	has the meaning given in section 1.2 of Schedule 7 ("Claims File Transfer").
Delay	has the meaning given in clause 52.1.
Deliverable	any Material, Documentation or other item to be supplied by the Claims Service Provider under this Contract (excluding any Material or process that is used by the Claims Service Provider to create or supply that Material, Documentation or other item and is not incorporated into that Material, Documentation or other item).
Delivery Proposal	has the meaning given in clause 40(a).
Demand	includes any allegation, causes, suits, rights, claims, debt, expenses, liability, losses, proceedings and demands of any nature, including any claim for damages, costs, interest or indemnity, and whenever present or future, fixed or ascertained, actual or contingent, however arising, known or unknown.

Digitisation Procedure	has the meaning given in section 1.3 of Schedule 8 ("Information Security and Management").
Direct Costs	(a) in respect of the Claims Service Provider, means the reasonable direct costs (including Shared Services costs that are directly attributable to the Project Services, subject to the Claims Service Provider providing evidence of such costs as requested by icare) over and above the Claims Service Provider's costs of performing the Services at the date of the relevant Project Services Request, Material Regulatory Change or Material Direction (as applicable) that are necessary to be incurred in order to implement the Project Service or activities contemplated as being chargeable under Section J-Directions and Change Management in respect of the relevant Material Regulatory Change or Material Direction, including, in respect of a Project Service, including any additional direct management expenses in supervising and managing the Project Service and after making allowance for any benefit that may flow to the Claims Service Provider or any of its Related Bodies Corporate in respect of any other part of their businesses arising out of the implementation of the Project Service. The Direct Cost will be calculated on the basis that the operations and systems of the Claims Service Provider at the date of the Project Services Request, Material Regulatory Change or Material Direction (as applicable) are operating at a level consistent with Best Industry Practice and must, where applicable, be in accordance with the hourly rates specified in Attachment 4.01 (Project Plan Approved Maximum Rates) of Schedule 4 ("Project Services Framework"); and (b) in respect of an Other Claims Service Provider, means the same category of costs as contemplated in paragraph (a) that are necessary to be incurred by that Other Claims Service Provider in order to implement the Project Service or activities contemplated in paragraph (a), as if it were the Claims Service Provider and operating in broadly comparable circumstances to those of the Claims Service Provider.
Direction or **Direct**	any direction which icare gives or issues, or is deemed to give or issue, under clause 39.1.

Disengagement Period	is the period up to 12 months or such longer period as reasonably required by icare and notified by icare to the Claims Service Provider until all Disengagement Services have been completed to the reasonable satisfaction of icare, commencing on the date on which the Claims Service Provider must commence providing the Disengagement Services under clause 60.1(a).
Disengagement Plan	the plan developed and updated by the Claims Service Provider in accordance with clause 60.3.
Disengagement Services	(a) the services required by the Claims Service Provider to effect an orderly transfer of the Services, functions and operations provided or required to be provided by the Claims Service Provider under the Contract to a new Claims Service Provider, an Other Claims Service Provider or to icare itself, as set out in the Disengagement Plan; and (b) the continuation of the Services until the end of the Disengagement Period in accordance with the Disengagement Plan.
Dispute Notice	has the meaning given in clause 57.2(a)(i).
Document or **Documentation**	documentation in any form (including in machine readable or other form) and includes reports, records, specifications, user or technical manuals, designs, plans, spread sheets, drawings or pictures in any format.
Draft Disengagement Plan	the draft plan developed by the Claims Service Provider in accordance with clause 60.3(a).
Draft Pandemic Risk Management Plan	has the meaning given in clause 54.7(c).
Eligible Employer(s)	an Employer within the category of Employers for which icare permits employer choice of claims service provider as notified by icare from time to time.
Employer	a business (including an individual) that employs or hires Workers or deemed Workers within the meaning of the 1987 Act and the 1998 Act on a full-time, part-time or casual basis, under an oral or written contract of service or apprenticeship, including the selected Employers.

Equipment	the systems, hardware, software and telecommunications systems that are owned, licensed, procured by, or subject to the control of, the Claims Service Provider or Service Company (and their respective Personnel) and are used to perform or deliver the Services. To avoid doubt, Equipment includes software and hardware sourced by the Claims Service Provider as a service or provided to the Claims Service Provider by icare.
Extension Period	Extension Period 1 and/or Extension Period 2.
Extension Period 1	the period stated in the Contract Details.
Extension Period 2	the period subsequent to Extension Period 1 and as stated in the Contract Details.
External Complaint	a complaint that is received from an external agency, such as IRO, SIRA, NSW Ombudsman, IPC NSW or NCAT.
Extract List	a summary listing of Claims selected by icare for transfer as described in Schedule 7 (“Claims File Transfer”).
Fault	has the meaning given in clause 56.4(a).
Fees	the fees for the Services as detailed in Schedule 2 (“Remuneration”), including its Attachments.
File Stakeholders	all interested parties to a Claims File active within the last 12 months, including but not limited to the Employer, Worker, any Third Party Service Providers, PIC or IRO.
File Status Report	the reports required at each stage of the Claims File Transfer to be completed by the Claims Service Provider in the form provided by icare from time to time.
Final Adjustment	a positive or negative adjustment in relation to an Interim Payment once additional information becomes available in respect of the payment.
Final Critical Milestone	the Milestone specified as such in (or if not separately referenced, the final Milestone to complete the Services under) the Transition-In Plan, Claims File Transfer Requirements, Disengagement Plan or any Statement of Work.
Final Critical Milestone Date	the date referred to as such (or if not separately referenced, the Milestone Date for the Milestone which is the Final

	Critical Milestone) in the Transition-In Plan, Claim File Transfer, Disengagement Plan or any Statement of Work.
Financial Security	an irrevocable standby letter of credit, bank guarantee or other irrevocable and unconditional promise to pay, in each case, in favour of icare, for an amount of at least the amount set out in the Contract Details and satisfying the requirements of clause 27, and in all cases in form and substance acceptable to icare.
Financial Year	means: (a) the period from the Commencement Date to 30 June 2023; (b) the 12 month period starting on 1 July 2023; and (c) each subsequent 12 month period (or part of that period) starting on 1 July, during the Term.
Force Majeure Event	is limited to: (a) an act of God, lightning strike, meteor strike, earthquake, storm, flood, water damage, landslide, extreme heat conditions, explosion, fire, unexpected electromagnetic interference caused by unlicensed or illegal transmission of electromagnetic energy or interference which is not reasonably foreseeable, or collapse of structures; (b) disruption of facilities or systems caused by the impact of an aircraft, ship, vessel or vehicle; (c) strikes or other industrial action, other than strikes or other industrial action primarily involving some or all the party's employees, or employees of its subcontractors or agents; (d) war (declared or undeclared), terrorism, sabotage, blockade, revolution, riot, insurrection, civil commotion or disorder or rebellion, the consequence of which: (e) is beyond the control of and was not caused or contributed to by the party which is seeking to rely on the event; (f) could not have been reasonably prevented or remedied by expenditure by the party which is seeking to rely on the event;

	(g) cannot be circumvented by the party which is seeking to rely on the event through the use of other practicable means including alternate sources and work around plans which provide a viable solution for the other party, as determined by that other party acting reasonably; and (h) could not have been prevented by the operation of the Business Continuity Plan.
Foreground Material	(a) Claims Service Provider Operational Data; (b) Project Material (subject to clause 11.1(b)); (c) all Material created or otherwise brought into existence by or on behalf of the Claims Service Provider, its Personnel or any other member of the Claims Service Provider Group or their respective Personnel, on or after the Commencement Date for the purpose of or as a result of performing its obligations under this Contract; (d) all Material created or otherwise brought into existence by or on behalf of the Claims Service Provider, its Personnel or any sub-licensee of the Claims Service Provider or their respective Personnel that is a modification to icare Material; and (e) all Material copied or derived from the Material referred to in paragraphs (a) to (d) above, but excluding the Records.
Fraud	includes fraud on the Workers Compensation Scheme as described in section 235A of the 1998 Act, or suspected conduct that would, if proven, amount to such fraud.
Fraud Risk Management Model	the Claims Service Provider's framework that enables the prevention, identification and management of internal and external Fraud and includes the requirements detailed in Schedule 1 ("Customer Engagement & Claims Management Services").
Fund Loss	any loss, liability, damage, cost or expense of the Relevant Fund of any kind (including any diminution in the value of the assets of the Relevant Fund or the deprivation of any gain to which the Relevant Fund would otherwise be entitled).
GIPA Act	the *Government Information (Public Access) Act 2009* (NSW).

Governance Framework	the framework established under section 3 of Schedule 3 ("Performance Management & Governance").
Government Agency	(a) a department of state; (b) a body corporate or an unincorporated body, Authority or office established or constituted for a public purpose by any Law of the Commonwealth or a State or Territory, or an instrument made under that authority (including a local authority); (c) a body established by the Governor-General, a State Governor, or by a Minister of State of the Commonwealth, a State or Territory; or (d) an unincorporated company over which the Commonwealth, State or Territory exercises control.
GST	any tax imposed by the Commonwealth of Australia on the supply of goods and services or things, whether described as a goods and services tax, value added tax or any other like tax.
GST Act	*A New Tax System (Goods and Services Tax) Act 1999* (Cth).
GST Law	has the meaning given in the GST Act.
Guarantor	a holding company of the Claims Service Provider or other person Approved by icare who has executed a Performance Guarantee pursuant to a request under clause 26.
Health Information	has the meaning given in the *Health Records and Information Privacy Act 2002* (NSW).
icare	has the meaning given in item 1 of the Contract Details, and is a party to this Contract.
icare Partnering and Performance Manager	the person named as such in item 10 of the Contract Details or such other person as icare may nominate in writing from time to time
icare Authorised Representative	the person appointed by icare who is authorised to represent icare in accordance with clause 43.
icare Database	the data repository used by icare.
icare Logos	the logos or other trade marks notified by icare to the Claims Service Provider from time to time.

icare Material	(a) Foreground Material; (b) Records; (c) the Monitoring Tool; (d) the icare Database and any Material that is held in the icare Database; (e) any Material that is provided to the Claims Service Provider by icare before or after the Commencement Date, including Material that is owned by or licensed to icare and in the possession or control of the Claims Service Provider or its Personnel; and (f) any Material that is otherwise created or brought into existence by or on behalf of icare (other than by the Claims Service Provider, its Personnel or any other member of the Claims Service Provider Group or their respective Personnel) in connection with this Contract, and excludes icare Logos.
icare Operational Materials	those Documents prepared by icare and made available to the Claims Service Provider, which detail processes and information used in the day to day provision of the Services.
icare Policy	a policy of icare that is relevant to the provision of the Services.
icare Resources	has the meaning given in clause 48.2.
Incident Management Plan	a document that provides a set of instructions to an organisation, helping in detecting, responding and recovering from an unplanned security event such as a Personal Information Security Incident, cyber-attack and service outages that impact the business as usual activities.
Independent Review Office or **IRO**	the statutory office of that name established under Schedule 5 of the *Personal Injury Commission Act 2020* (and includes any member of the staff of that officer).
Information Security Plan	a documentation of an organisation's security policies, procedures and controls implemented to achieve higher levels of information security. The information security plan also provides an overview of the responsibilities and behaviour of all individuals accessing the information systems/assets.
Information Security Policy	a set of rules and procedures issued by an organisation to ensure the confidentiality, integrity and availability of the organisation's information. All Personnel having access to

	the information or systems/assets are required to comply with the rules and guidelines mentioned in the information security policy to protect the information within the organisation's boundaries of authority.
Initial Contract Term	the period set out in the Contract Details, starting on the Commencement Date.
Injury	a personal injury arising out of, or in the course of employment within, the meaning of section 4 of the 1987 Act and section 4 of the 1998 Act.
Injury Management	the process that comprises activities and procedures that are undertaken or established for the purpose of achieving a timely, safe and durable Return to Work for Workers following an Injury.
Injury Management Plan	a document which provides information for an injured Worker and Employer with a focus on documenting information relating to the Worker's Return to Work and recovery goals. The plan is developed in collaboration with the injured Worker, the Employer and the Nominated Treating Doctor.
Injury Management Program	the program of the same name established in accordance with section 43 of the 1998 Act.
Input Tax Credits or **ITC**	has the same meaning as in the GST Act.
Insolvent	a person is **Insolvent** if: (a) it is (or states that it is) an insolvent under administration or insolvent (each as defined in the Corporations Act); (b) it is in liquidation, in provisional liquidation, under administration or wound up or has had a Controller appointed to its property; (c) it is subject to any arrangement (including a deed of company arrangement or scheme of arrangement), assignment, moratorium, compromise or composition, protected from creditors under any statute or dissolved (in each case, other than to carry out a reconstruction or amalgamation while solvent on terms approved by the other party to this document); (d) an application or order has been made (and in the case of an application which is disputed by the

	person, it is not stayed, withdrawn or dismissed within 14 days), resolution passed, proposal put forward, or any other action taken, in each case in connection with that person, which is preparatory to or could result in any of the things described in any of the above paragraphs; (e) it is taken (under section 459F(1) of the Corporations Act) to have failed to comply with a statutory demand; (f) it is the subject of an event described in section 459C(2)(b) or section 585 of the Corporations Act (or it makes a statement from which another party to this document reasonably deduces it is so subject); (g) it is otherwise unable to pay its debts when they fall due; or (h) something having a substantially similar effect to any of the things described in the above paragraphs happens in connection with that person under the Law of any jurisdiction.
Instrument of Acceptance	an instrument of acceptance substantially in the form provided by icare from time to time.
Intellectual Property Rights	(a) all rights conferred by Law and subsisting anywhere in the world in relation to: (i) all copyright (including rights in relation to phonograms and broadcasts); (ii) inventions (including patents, innovation patents and utility models); (iii) Confidential Information, trade secrets, Technical Data and know-how; (iv) registered and unregistered designs; (v) registered and unregistered trademarks; (vi) circuit layout designs, topography rights and rights in databases, whether or not any of these are registered, registrable or patentable; (b) any other rights resulting from intellectual activity in the industrial, commercial, scientific, literary or artistic fields which subsist or may hereafter subsist; (c) any applications and the right to apply for registration of any of the above; and

	(d) any rights of action against any third party in connection with the rights included in paragraphs (a) to (c) above, but excluding Moral Rights.
Interim Payment	any payment made on account by icare in respect of a best estimate amount based on the information available at the time of the payment.
Internal Controls	the Claims Service Provider's checks and measures to ensure that appropriate policies and procedures are in place within the Claims Service Provider.
Issue	a weakness or gap which, if not addressed, could lead to an adverse impact on icare, its customers or its Personnel.
Key Input Provider	a person (other than an employee of the Claims Service Provider) who: (a) performs any part of the Services or other obligations under this Contract who is to be remunerated more than $250,000 per annum, or is otherwise designated as a Key Input Provider by icare having regard to the extent or sensitivity of the work to be performed; or (b) provides more than 15% of the Personnel used to provide the Services; or (c) is a Service Company.
Key Input Provider Register	the register of Key Input Provider referred to in clause 30.3, and as updated under clause 30.3.
Key Personnel	(a) the Claims Service Provider Authorised Representative, Claims Service Provider Partnering and Performance Manager and any personnel of the Claims Service Provider who directly report to the Claims Service Provider Authorised Representative or the Claims Service Provider Partnering and Performance Manager; and (b) any other roles or personnel reasonably requested by icare in writing.
Large Employer	(a) as at the Commencement Date, an Employer whose Basic Tariff Premium for an insurance policy at the time the insurer demands a premium for the policy: (i) is equal to or exceeds $500,000 (where the period of insurance to which the premium relates is 12 months); or

	(ii) is equal to or exceeds $500,000 (where the period of insurance to which the premium relates is not 12 months) if that premium was calculated using a period of insurance of 12 months, where, if an Employer is a member of a group, a reference to the Basic Tariff Premium of the Employer or to total wages payable by the Employer to Workers (however expressed), is taken to be a reference to the sum of the Basic Tariff Premiums of all members of the group or to total wages payable to Workers by all members of the group, respectively; or (b) such other Employer as icare otherwise advises.
Law	(a) any statute, regulation, by-law, ordinance or subordinate legislation in force in Australia, whether made by a State, Territory, Commonwealth, or a local government; and (b) common law and the principles of equity.
Licensed Claims Service Provider Material	all Material which falls within paragraphs (a) or (b) of the definition of Claims Service Provider Material.
Liquidated Damages	has the meaning given in clause 52.6.
Location Proposal	has the meaning given in clause 10(b).
Long Tail Claim	a Claim that: (a) is non-premium impacting for Employers at the Commencement Date (date of Injury prior to 1 January 2012); and (b) was opened prior to the 2012 Legislative Reforms (Claims with a date of Claim prior to 1 October 2012); and (c) has been transitioned to the *Work Health and Safety Act 2011* (NSW) and Regulations but remain active within the Scheme; or (d) is directed by icare as being a Long Tail Claim.
Loss Prevention Recovery Policies or **LPR Policies**	the alternative methods by which premiums are calculated related to Large Employers (if such Large Employers elect) derived from Claims costs.

Malware	a computer program that is covertly placed onto a computer or electronic device with the intent to compromise the confidentiality, integrity, or availability of Data, applications, or operating systems. Common types of Malware include viruses, worms, malicious mobile code, Trojan horses, rootkits, spyware, and some forms of adware, intended to: (a) disable, damage, erase, disrupt or impair the normal operation of any hardware, software or system; (b) permit unauthorised access or use of hardware, software or systems; or (c) assist in or enable unauthorised access to, or disclosure of or destruction or corruption of Data.
Manuals	the Documents identified by icare as being a 'manual', a 'guide' or a 'guideline' prepared by icare and which describe certain technical requirements, guidelines and instructions for the performance of the Services. The Manuals applying at the Commencement Date are the Claims Estimation Manual (Attachment 1.02), the Banking Manual (Attachment 5.01) and the Taxation Manual (Attachment 5.02).
Material	material in any form including Documents, goods, information, equipment, software (in source code and object code), software tools, software development methodologies and data stored by any means including all copies and extracts of the same and anything else which is the subject matter of Intellectual Property Rights.
Material Project	a Project for which the Claims Service Provider's incremental Direct Costs of performance are determined to exceed $100,000.
Material Regulatory Change	has the meaning given in clause 38.1.
Measures	has the meaning given in clause 41.4(a).
Medium Employer	(a) as at the Commencement Date, an Employer whose Basic Tariff Premium for an insurance policy at the time the insurer demands a premium for the policy: (i) is equal to or exceeds $30,000, but does not exceed $499,999.99 (where the period of

	insurance to which the premium relates is 12 months); or (ii) is equal to or exceeds $30,000, but does not exceed $499,999.99 (where the period of insurance to which the premium relates is not 12 months) if that premium was calculated using a period of insurance of 12 months, where, if an Employer is a member of a group, a reference to the Basic Tariff Premium of the Employer or to total wages payable by the Employer to Workers (however expressed), is taken to be a reference to the sum of the Basic Tariff Premiums of all members of the group or to total wages payable to Workers by all members of the group, respectively; or (b) such other Employer as icare otherwise advises.
Meetings	the meetings and forums set out in Schedule 3 ("Performance Management & Governance"), including the Performance & Operational Meetings and Strategic Review Meetings.
Milestone	a key Deliverable or event in the delivery of any Service that is described in any plan in respect of this Contract, including the Transition-In Plan, Claims File Transfer, the Disengagement Plan or a Statement of Work, for which Approval or Acceptance is required.
Ministerial Complaint	a complaint about icare or the Scheme made to a Minister of the NSW government responsible for icare.
Milestone Date	the date for achievement of a Milestone.
Modern Slavery	has the same meaning as in the Modern Slavery Laws and includes slavery, servitude, forced labour, human trafficking, debt bondage, organ trafficking, forced marriage and the exploitation of children.
Modern Slavery Laws	the *Modern Slavery Act 2018* (Cth) and any other applicable Laws addressing similar subject matter.
Modern Slavery Offence	has the same meaning as in the Modern Slavery Laws.
Modern Slavery Statement	a modern slavery statement as required or volunteered under the Modern Slavery Laws.
Moody's	Moody's Investor Service, Inc.

Monitoring Tool	the tool provided by icare for the Claims Service Provider to assess its performance.
Month	calendar month
Moral Rights	has the same meaning given to it as that term is defined in Part IX of the *Copyright Act 1968* (Cth).
Near Miss	unauthorised access to or unauthorised disclosure of Personal Information or a loss of Personal Information that could have resulted in an adverse impact on icare or its Personnel, a Worker, an Employer or any other third party but was narrowly avoided.
Nominal Insurer	the Workers Compensation Nominal Insurer established by Division 1A of Part 7 of the 1987 Act, as inserted by the *Workers Compensation Amendment (Insurance Reform) Act 2003* (NSW).
Nominated Treating Doctor	the doctor responsible for coordinating all aspects of treatment and Return to Work management (as defined for all parts of the Contract other than Schedule 2 ("Remuneration") and Schedule 3 ("Performance Management & Governance")), and who is authorised by the injured Worker to provide the Employer and Claims Service Provider with Information relating to the Injury and rehabilitation in accordance with Chapter 3 of the 1998 Act.
Non-material Project	a Project that is not a Material Project.
Notice of Change	has the meaning given in clause 41.2(a)(ii).
Notice of Measure Change	has the meaning given in clause 41.4(a).
Notification	a notification made within the meaning of section 44 of the 1998 Act.
NSW Auditor General	the Auditor-General of New South Wales, as appointed under the *Government Sector Audit Act 1983* (NSW), and includes any employee or other representative of that person.
NSW Audit Office	the Audit Office of New South Wales established under the *Government Sector Audit Act 1983* (NSW).

NSW Government Cyber Security Policy	the "NSW Cyber Security Policy" issued by the NSW government (currently version 5) as updated from time to time.
NSW Government Procurement: SME and Regional Policy	the NSW government's policy titled "Small and Medium Enterprise and Regional Procurement Policy" as updated from time to time.
NSW Procurement Policy Framework	the NSW government's policy titled "Procurement Policy Framework" as updated from time to time.
Other Claims Service Providers	all persons with whom icare has entered into agency arrangements or arrangements similar to this Contract in relation to Claims Management.
Open Claim	a Claim with an "Open" Claim status regardless of whether there is active management during the then current Quarter or a new positive payment made in the previous Quarter.
Operational Measure	the performance measures designed to drive and support ongoing improved performance as set out in Attachment 3.01 (*Operational Measures*).
Operational Measures Register	has the meaning given to it in section 4.2(a)(iii) of Schedule 3 ("Performance Management & Governance").
Outcome Measure	the key outcomes icare is seeking from the Claims Service Provider as set out in Attachment 2.02 (*Outcome Measures*) and which are used in the calculation of the Annual Outcome Fee in accordance with Schedule 2 ("Remuneration").
Pandemic Risk Management Plan	has the meaning given in clause 54.7(c).
Panel	icare's panel of providers who have each entered into a standing offer agreement with icare to provide Third Party Service Provider services to the Scheme.
Panellist	a Third Party Service Provider that is a member of a Panel.
Partnering and Performance Manager	either the Claims Service Provider Partnering and Performance Manager or icare Partnering and Performance Manager (as the case requires).
Payment Account	the Relevant Fund bank account that is allocated to the Claims Service Provider by icare from which the Claims

	Service Provider pays Benefits and Third Party Service Providers.
Payment Transactions	the number of individual payments made by a Claims Service Provider during a period as recorded in the CDR.
Performance Guarantee	a guarantee of performance, including financial obligations, from a Related Body Corporate of the Claims Service Provider, in substantially the form set out in Schedule 10 ("Form of Performance Guarantee"), or such other form as otherwise agreed to by icare.
Performance Management Register or **PMR**	the register described in clause 4.3(b) of Schedule 3 ("Performance Management & Governance").
Performance Measures	collectively Outcome Measures, Quality Measures and Operational Measures or any other performance measures which are directed by icare or agreed by the Parties.
Personal Information	any personal information as defined in the *Privacy and Personal Information Protection Act 1998* (NSW) or any Health Information.
Personal Information Security Incident	misuse, unauthorised access to or unauthorised disclosure of Personal Information or a loss of Personal Information.
Personal Injury Commission or **PIC**	the Personal Injury Commission as established under Part 2 of the *Personal Injury Commission Act 2020*.
Personnel	(a) of any person other than the Claims Service Provider or icare, includes an employee, contractor, agent, officer, and director of that person; (b) of the Claims Service Provider, includes an employee, contractor, agent, officer, director, advisor or Subcontractor (including employees, contractors, agents, officers and directors of Subcontractors) of the Claims Service Provider, including Key Personnel and Personnel of Key Input Providers and Service Companies, but excluding any Third Party Service Provider; and (c) of icare, includes an employee, contractor, agent, officer, director, advisor or subcontractor (including employees, contractors, agents, officers and directors of subcontractors) of icare, including the icare Authorised Representative and icare Partnering and

	Performance Manager, but excluding the Claims Service Provider and its Personnel.
PIC	the New South Wales Personal Injury Commission.
Platform Changes	has the meaning given in section 4.1 of Schedule 9 ("Claims Technology Platform").
Policy	a policy of insurance that an Employer obtains under the 1987 Act.
Policyholder	an Employer with a Policy with icare.
Portfolio	the claims portfolio set out in item 6 of the Contract Details, as may be amended from time to time in accordance with this Contract.
Portfolio and Performance Meeting	the meeting described in section 3.2(b) of Schedule 3 ("Performance Management & Governance").
Portfolio and Performance Meeting Charter	has the meaning given in section 3.2(b)(iii) of Schedule 3 ("Performance Management & Governance").
Pre-Existing Agreement	has the meaning given in clause 10(b).
Primary Psychological Injury	has the meaning given in section 65A of the 1987 Act.
Privacy Management Plan	a privacy management plan prepared in accordance with section 33 of the *Privacy and Personal Information Protection Act 1998* (NSW) and Schedule 8 ("Information Security and Management").
Project	a discrete, ad hoc Deliverable or Service that is not, prior to being included in a Statement of Work, included within the scope of this Contract (excluding secondments of personnel by the Claims Service Provider to icare to support icare's retained activities).
Project Aggregate Threshold	$250,000
Project Material	any Material that is created or otherwise brought into existence by or on behalf of the Claims Service Provider, its Personnel or any other member of the Claims Service

	Provider Group or their its respective Personnel for the purpose of or as a result of performing a Project Service, a Statement of Work or approved Delivery Proposal.
Project Plan	a plan which describes the activities that will be undertaken and the processes that will be followed by the Claims Service Provider in relation to the management of a Project Service.
Project Services	services that are: (a) in respect of a Project; and (b) provided under a Statement of Work in accordance with clause 11 or clause 40, and Schedule 4 ("Project Services Framework").
Project Services Request	a request for Project Services in accordance with the requirements of clause 1.1 of Schedule 4 ("Project Services Framework").
Project Services Response	a response to a Project Services Request in accordance with the requirements of clause 1.2 of Schedule 4 ("Project Services Framework").
Qualifying Invoice	a Tax Invoice for a Third Party Service Provider's services that meets all the criteria set out in clause 14.
Quality Management Framework	the programs, practices and measurers implemented by the Claims Service Provider to ensure the provision of a high quality, contemporary, timely and accountable Service, in accordance with Schedule 3 ("Performance Management & Governance").
Quality Measure	the minimum standards that the Claims Service Provider must achieve in the delivery of Services under this Contract as set out in Attachment 2.01 (*Quality Measures*) and which are used in the calculation in the Annual Quality Fee in accordance with Schedule 2 ("Remuneration").
Quality Measures Register	has the meaning given to it in section 4.2(b) of Schedule 3 ("Performance Management & Governance").
Quarter or **Quarterly**	each three month period commencing 00:00:00 1 January, April, July and October each Calendar Year and ending at 23:59:59 on 31 March, 30 June, 30 September and 31 December respectively.
Receiving Claims Service Provider	the Claims Service Provider, an Other Claims Service Provider, or other person, to which responsibility for a

	particular Claim that has been, or may be, transferred under a notice from icare.
Recipient	has the meaning given in clause 19.2(c).
Recipient Created Adjustment Note	an Adjustment Note issued by the Recipient.
Records	all records, Documents, information and data that is made or kept, or received and kept, by the Claims Service Provider in the exercise of its functions, on behalf of icare.
Regulatory Guidance	has the meaning given in clause 23.2(b).
Related Body Corporate	has the meaning given in the Corporations Act.
Relevant Fund	has the meaning given in item 7 of the Contract Details.
Remediation Plan	a plan prepared by the Claims Service Provider to address underperformance or non-compliance by the Claims Service Provider.
Remediation Plan Direction	has the meaning given in paragraph 53.2(a).
Remuneration	payments to the Claims Service Provider for performing Services during the Term as set out in clause 13 and Schedule 2 (“Remuneration”).
Reporting Period	in relation to a Performance Measure is the reporting period specified in respect of a Performance Measure or an element of a Performance Measure.
Return to Work or **RTW**	in all parts of the Contract other than in Schedule 2 (“Remuneration”) and Schedule 3 (“Performance Management & Governance”), the process by which a Worker is obliged to make best endeavours to return to work in Suitable Employment or pre-Injury employment at the Worker’s place of employment or at another place of employment within the meaning of section 48 of the 1998 Act.
S&P	Standard & Poors (Australia) Pty Limited.
Schedule	each of the schedules attached to this Contract.

Scheme	the part of the Workers Compensation system which is administered by icare.
Scheme-Wide Risk Workshop	the meeting described in clause 3.2(f) of Schedule 3 ("Performance Management & Governance").
Scheme Agent	has the meaning set out in the 1987 Act.
Scheme Outcomes	improved service delivery for Employers and Workers, improved Return to Work outcomes and improved financial performance of the Scheme.
Self Insurer	a person who holds a licence as a self-insurer under Division 5 of Part 7 of the 1987 Act.
Service Company	(a) a Related Body Corporate; (b) an associated entity within the meaning of section 50AAA of the Corporations Act; or (c) a partner or joint venturer, of the Claims Service Provider who employs Personnel or owns assets which are used by the Claims Service Provider in the performance of the Services, as Approved by icare and identified in item 9 of the Contract Details.
Service Desk Support Model	has the meaning given in section 3.3 of Schedule 9 ("Claims Technology Platform").
Services	the work required to be performed by the Claims Service Provider in accordance with the Contract, including: (a) all services and requirements described in Schedule 1 ("Customer Engagement & Claims Management Services"), including as required for the allocated Portfolio, and Schedule 5 ("Banking and Financial Management") and any Attachments to those Schedules, and which for the avoidance of doubt includes any Direction issued under this Contract; (b) all obligations to undertake activities, or provide Deliverables or outputs in the clauses of the Contract or in any Schedule; (c) the Transition-In; (d) the Project Services; and (e) the Disengagement Services,

	and includes any service or work that is necessary or incidental to the provision of the Services or by virtue of the Law.
Services Commencement Date	the date specified in item 4 of the Contract Details.
Shared Services	the consolidation of business operations that are used by multiple parts of the same organisation and not limited to the Claims Service Provider's provision of Services under this Contract. This includes but is not limited to human resources, finance and information technology operations.
SI Corp	the NSW Self Insurance Corporation that operates under the *NSW Self Insurance Corporation Act 2004* (NSW).
Significant	a matter which is likely to have a serious and quantifiable reputational, commercial or economic impact on icare or one or more other NSW government entity or is likely to establish a precedent.
Small Business	has the meaning set out in the Small Business Shorter Payment Terms Policy.
Small Business Shorter Payment Terms Policy	the NSW government's policy titled "Small Business Shorter Payment Terms Policy" as updated from time to time.
Small Employer	(a) as at the Commencement Date, an Employer whose Basic Tariff Premium for an insurance policy at the time the insurer demands a premium for the policy: (i) does not exceed $30,000 (where the period of insurance to which the premium relates is 12 months); or (ii) would not exceed $30,000 (where the period of insurance to which the premium relates is not 12 months) if that premium was calculated using a period of insurance of 12 months, where, if an Employer is a member of a group, a reference to the Basic Tariff Premium of the Employer or to total wages payable by the Employer to Workers (however expressed), is taken to be a reference to the sum of the Basic Tariff Premiums of all members of the group or to total wages payable to Workers by all members of the group, respectively; or

	(b) such other Employer as icare otherwise advises.
SME and Local Participation Plan	the plan of that name developed pursuant to the Small and Medium Enterprise and Regional Procurement Policy and Approved by icare in accordance with clause 25.1.
SME Policies	(a) NSW government Procurement: SME and Regional Policy; (b) Small Business Shorter Payment Terms Policy; and (c) other NSW government policies relating to small and medium businesses.
Special Conditions	any terms or conditions that vary or are additional to the Contract Terms and which are set out in Schedule 11 ("Special Conditions"), but do not include any Claims Service Provider document.
Specialised Insurer	an insurer who holds a licence as a specialised insurer under Division 3 of Part 7 of the 1987 Act.
Specified Supplies	for the purpose of clause 20.4, means the supplies for which the fees specified in clause 13.1(a) are consideration, including any Interim Payment or Final Adjustment of those fees.
Standard Complaint	a complaint where issues are clearly defined, and a detailed investigation or written response is not required.
Strategic Leadership Meeting	the meeting described in section 3.2(d) of Schedule 3 ("Performance Management & Governance").
Strategic Leadership Meeting Charter	has the meaning given in section 3.2(d)(iii) of Schedule 3 ("Performance Management & Governance").
State Insurance Regulatory Authority or **SIRA**	the State Insurance Regulatory Authority as constituted under Part 3 of the *State Insurance and Care Governance Act 2015* (NSW).
State Privacy Laws	has the meaning given in clause 37.1(a)(i).
Statement of Work	a written order for Project Services and substantially in the form of Attachment 4.03 (*Statement of Work Template*) to Schedule 4 ("Project Services Framework").

Subcontractor	any subcontractor or agent and their respective directors, officers, employees, engaged by the Claims Service Provider to fulfil some of the Claims Service Provider's obligations to perform the Services, and includes a Key Input Provider under paragraph (a) of the definition of that term, but excludes a Third Party Service Provider. A Related Body Corporate may be a Subcontractor.
Suitable Employment	employment in work which the Worker is currently suited: (a) having regard to: (i) the nature of the Worker's incapacity and the details provided in medical information including, but not limited to, any Certificate of Capacity supplied by the Worker (under section 44B of the 1987 Act); (ii) the Worker's age, education, skills and work experience; (iii) any plan or Document prepared as part of the Return to Work planning process, including an Injury Management Plan; (iv) any occupational rehabilitation services that are being, or have been, provided to or for the Worker; and (v) such other matters as the WH&S and Workers Compensation Legislation may specify, and (b) regardless of: (i) whether the work or the employment is available; (ii) whether the work or the employment is of a type or nature that is generally available in the employment market; (iii) the nature of the Worker's pre-Injury employment; and (iv) the Worker's place of residence.
Suspect Activity	any conduct or behaviour which might give rise to an allegation of a contravention of Workers Compensation Laws.
Target	has the meaning given in Schedule 2 ("Remuneration").

Tax Invoice	an invoice that is in a form that complies with the GST Act, but does not include a Recipient Created Tax Invoice issued under clause 20.4.
Technical Data	all research materials, technical reports, test results, analysis, computer programs, computer data bases, computer and software routines, network and topology diagrams and information, working papers, drawings, specifications, formulae, manufacturing processes, recipes, operating procedures and other technical and scientific data and information of whatever kind relating to any Workers Compensation Scheme.
Term	the Initial Contract Term plus any extension exercised in accordance with clause 4.3(a) plus the Disengagement Period.
Termination for Convenience Cap	the amount set out in Schedule 2 ("Remuneration") that relates to the time period during which the effective date of termination under clause 59.1(a) occurs.
Termination for Convenience Charge	is the lesser of: (a) an amount equal to the sum of: (i) any fees that the Claims Service Provider has incurred reasonably or is liable to incur reasonably under contracts with third party service providers, to the extent that the fees: (A) relate to goods and services provided by those third parties that relate to the Claims Service Provider's performance of the Contract up to the date of termination; and (B) could not be avoided or mitigated by the Claims Service Provider taking all reasonable steps to do so; (ii) any penalties or charges that the Claims Service Provider is liable to pay under a contract with a third party service provider, to the extent that the penalties or charges: (A) arise directly from the termination, reduction or descoping of goods and services under that contract as a direct result of the termination of this Contract under clause 59.1(a); and

	(B) could not be avoided or mitigated by the Claims Service Provider taking all reasonable steps to do so; and (iii) any redundancy payments that the Claims Service Provider is liable to pay to Personnel employed by the Claims Service Provider who were dedicated to the icare account and whom the Claims Service Provider was not able to redeploy within its organisation, to the extent that those payments could not be avoided or mitigated by the Claims Service Provider taking all reasonable steps to do so; and (b) the Termination for Convenience Cap.
Third Party Dispute	any Demand by a third party brought against the Claims Service Provider arising out of or in relation to the Services under this Contract, including but not limited to legal proceedings, administrative appeals and regulatory investigations.
Third Party Service Provider	any person that provides services (exclusively or otherwise): (a) for which an Employer is liable to pay under the 1987 Act or the 1998 Act that may include medical or related assessments, examinations or reports for the purposes of the 1987 or 1998 Acts, legal services, medical or health services; or (b) that are services other than those in paragraph (a) and are Approved by icare.
Third Party SP Payment	an amount which is payable to a Third Party Service Provider, and which does not form any component of the Remuneration.
Transfer Date	the date on which the selected Claims Files are transferred.
Transfer Lead	the coordinator appointed by icare to assist the Claims Service Provider and Other Claims Service Providers in the coordination of the Claims File Transfer.
Transfer Period	the full duration of time that supports the Claims File Transfer activities from planning through to Claims File receipt activities and audits/closure as set out in the Schedule 7 (“Claims File Transfer”).

Transferring Claims Service Provider	the Claims Service Provider, an Other Claims Service Provider or other person, from whom a Claim is being transferred.
Transition-In	the transition of the performance of Services to the Claims Service Provider (including the preparation of systems, transfer of assets and management) under the Contract.
Transition-In Period	is the period of time from the Commencement Date until the Transition-In is Accepted in accordance with clause 5.3.
Transition-In Plan	the plan to be prepared by the Claims Service Provider in accordance with clause 5.1 for the Transition-In of the performance of Services to the Claims Service Provider.
Treasury Managed Fund	a government managed fund scheme within the meaning of section 3 of the *NSW Self Insurance Corporation Act 2004* (NSW). The SI Corp operates the TMF through icare, which provides services to SI Corp pursuant to section 10 of the *State Insurance and Care Governance Act 2015* (NSW).
Triage	a Claims Management activity that involves the classification and segmentation of notifications and Claims into groups according to specific requirements of the Claim.
Triage Specialist	the subject matter expert whose role is to apply Triage practices to support the identification and understanding of risk on Claims and assign them to appropriate service segments.
Update Notice	has the meaning given in clause 41.2(a)(i).
Uploaders	has the meaning given in section 4.3(c) of Attachment 5.01 (“Banking Manual”).
Urgent Direction	a Direction identified by icare, as urgent and to be implemented urgently.
Value Added Services	the services provided directly by the Claims Service Provider to Employers as permitted under the Contract and do not include the Services.
Wages	includes salary, overtime, shift and other allowances, bonuses, commissions, payment to working directors, payment for public and annual holidays, payments for sick leave, value of board and lodging provided by the Employer, or any other consideration paid to the Worker as described under the 1987 Act.

Wage Reimbursement Agreement	an agreement between the Claims Service Provider and the Employer authorising the Employer to make weekly Benefits to injured Workers and as set out in Schedule 1 ("Customer Engagement & Claims Management Services").
Wage Reimbursement Schedule	has the meaning given in the Wage Reimbursement Agreement.
WH&S and Workers Compensation Legislation	includes: (a) *Workers Compensation Act 1987* (NSW); (b) *Workplace Injury Management and Workers Compensation Act 1998* (NSW); (c) Workers Compensation Regulation 2016 (NSW); (d) *Work Health and Safety Act 2011* (NSW); (e) Work Health and Safety Regulation 2017 (NSW); (f) any other Law that governs WH&S or Workers Compensation in NSW; and (g) any ancillary rules, guidelines, orders, directions, directives, codes of conduct or other instruments made or issued thereunder which icare or the Claims Service Provider must comply with under Law.
Wilful Misconduct	any act or omission of a party which is wrongful and wilfully intended to harm the interests of the other party, provided however that negligence (including gross negligence), an error of judgment or mistake of a person, or an exercise of rights by a Party does not of itself amount to "Wilful Misconduct".
Work Capacity Assessment	a work capacity assessment under section 44A of the 1987 Act.
Work Capacity Decision	has the meaning given in section 43 of the 1987 Act.
Work Injury Damages or **WID**	a Claim for damages made under Part 5 of the 1987 Act.
Worker	a Worker within the meaning of the 1987 Act and includes a deemed Worker within the meaning of the 1998 Act, and an injured Worker who is or may be entitled to Benefits under the 1987 Act and/or the 1998 Act.

Workers Compensation	the scheme regulated by the 1987 Act and the 1998 Act that provides Benefits to Workers who sustain work-related Injuries.
Workers Compensation Insurance Fund" or "**WCIF**	the fund established under section 154D of the 1987 Act.
Workers Compensation Scheme	the Scheme, or any arrangement that includes Self Insurers, Specialised Insurers, or the Treasury Managed Fund.
Workers Compensation Schemes Claims Quality Assurance Framework	the framework described under Attachment 3.02 ("Workers Compensation Schemes Claims Quality Assurance Framework").
Workers Compensation Scheme Principles	the principles described in clause 1.2.
Workers with Highest Needs	has the meaning in section 32A of the 1987 Act.
Workers with Highest Needs Claims	those Claims defined as Workers with Highest Needs and as set out in Schedule 2 ("Remuneration").

64.2 Interpretation

In this Contract except where the context otherwise requires:

(a) a reference to any legislation, ordinance, code or other Law includes regulations under it and any consolidations, amendments, re-enactments or replacements of any of them;

(b) a reference to "**regulations**" includes instruments of a legislative character under legislation (such as regulations, rules, by-laws, ordinances and proclamations);

(c) the singular includes the plural and vice versa, and a gender includes other genders;

(d) another grammatical form of a defined work or expression has a corresponding meaning;

(e) a reference to a clause, paragraph, Schedule or Attachment is to a clause or paragraph of, or Schedule or Attachment to, this Contract and a reference to this

Contract includes any Schedule or Attachment to this Contract, as the context requires;

(f) a reference to a clause, section or paragraph includes a reference to a subclause of that clause, subsection of that section or subparagraph of that paragraph;

(g) a reference to a Document includes any agreement or other legally enforceable arrangement created by it (whether the document is in the form of an agreement, deed or otherwise);

(h) a reference to a Document, publication (including any SIRA publication), standard, icare policy or instrument also includes any variation, replacement or novation of it;

(i) any reference herein to any government body will include any successor entity of that government body having or performing substantially the same function;

(j) a reference to a party is to a party to this Contract, and a reference to a party to a Document includes the party's executors, administrators, successors and permitted assigns and substitutes;

(k) a reference to a person includes a natural person, partnership, body corporate, association, governmental or local Authority or agency or other entity;

(l) the meaning of general words is not limited by specific examples introduced by 'including', 'for example' or similar expressions;

(m) a reference to A$, $A, AUD, dollar or $ is to Australian currency unless stated otherwise;

(n) a reference to time is to Sydney time unless otherwise expressly stated;

(o) headings and sections titled "About this Contract" and "simplified outline of this Part" are for ease of reference only and do not affect interpretation;

(p) labels used for definitions are for convenience only and do not affect interpretation;

(q) a rule of construction does not apply to the disadvantage of a party because the party was responsible for the preparation of this Contract, or any of its parts;

(r) a reference to a matter being to the knowledge of a person means that the matter is to the best of the knowledge and belief of that person after proper inquiry including inquiry which a reasonable person would be prompted to make by reason of knowledge of a fact;

(s) any agreement, representation, warranty or indemnity in favour of two or more parties (including where two or more persons are included in the same defined term) is for the benefit of them jointly and severally;

(t) a word or expression defined in the Corporations Act has the meaning given in the Corporations Act;

(u) if a day on or by which an obligation must be performed or an event must occur is not a Business Day in the relevant location, the obligation must be performed or the event must occur on or by the next Business Day in that location;

(v) any agreement, representation, warranty or indemnity:

(i) by two or more parties (including where two or more persons are included in the same defined term) binds them jointly and severally; and

(ii) in favour of two or more persons is for the benefit of them jointly and each of them individually;

(w) a reference to a group of persons is a reference to any two or more of them jointly and to each of them individually;

(x) a reference to any thing (including an amount) is a reference to the whole and each part of it;

(y) a period of time starting from a given day or the day of an act or event, is to be calculated exclusive of that day; and

(z) if a party must do something under this document on or by a given day and it is done after 5.00pm on that day, it is taken to be done on the next day.

65. Administrative synergies

(a) The parties acknowledge that if at the Commencement Date the Claims Service Provider has in place, or during the Term enters into, a Claims Management Agreement with the NSW Self Insurance Corporation ("**TMF Agreement**"), there will be administrative benefits in combining governance and communications across this Contract and the TMF Agreement (together the "**Common Agreements**") where appropriate.

(b) Accordingly, the parties agree that on and from the time or times agreed by the Contract Representatives, either or both of the following provisions will apply:

(i) a notice given under one Common Agreement will, unless the party giving that notice states otherwise in its notice, be considered to be a notice given under the other Common Agreement; and

(ii) meetings convened under one Common Agreement, including under the governance schedule of the applicable Common Agreement, may be used as the equivalent meeting under the other Common Agreement.

Schedule 1 Customer Engagement & Claims Management Services

icare™
Insurance and Care NSW

Schedule 1

Customer Engagement & Claims Management Services

Table of contents

Overview

This Schedule sets out the requirements for customer engagement and the provision of Claims Management Services by the Claims Service Provider. This Schedule also details the parties' respective obligations dealing specifically with management of customer Complaints as part of managing the customer relationship.

Interpretation

(a) Capitalised terms used in this Schedule have the meaning set out in the Dictionary.

(b) Reference to "Key Parties" in this Schedule includes Workers and their representatives, Employers and their representatives, Nominated Treating Doctors and Third Party Service Providers as relevant.

(c) Reference to "customers" in this Schedule refers to Employers and Workers (as the context requires).

1. Scope of Services

1.1 End to end Claims Management Services

Unless stated otherwise in this Contract, the Claims Service Provider is responsible for the end to end provision of Claims Management Services, including the activities identified below:

Core Activities	Description of service
Lodgement, Triage and allocation	• Entering Claim lodgements received by phone, email, post, fax into the Claims Technology Platform • Policy verification • Claim coding, data entry and data integrity • Injury coding • Review of Triage recommendations and risk factors • Allocation of Claim to appropriate team/Case Manager
Stakeholder management	• Initial and ongoing contact with Key Parties • Activities to support Employer/Worker obligations and outcomes • Stakeholder management (e.g. with Third Party Service Providers)
Claims decisions, liability, investigations, work capacity	• Determining initial and ongoing liability and associated actions • Determining liability for treatment and associated actions • Conducting a Work Capacity Assessment • Making a Work Capacity Decision • Management of legal referrals and litigation • Dispute management

Core Activities	Description of service
	• Management of Work Injury Damages
Entitlements (including weekly payments, medical **and related treatment and other compensation)**	• Claims manual estimation (for Claims associated with Loss Prevention Recovery Policies) • Calculation of Pre-injury Average Weekly Earnings (PIAWE) and weekly payments • Injury coding, medical payment and data integrity • Payment of weekly Benefits, non-weekly Benefits and payment of other compensation • Payment of Benefits including lump sum, property damage, Commutation and death
Return to Work / stay at work and Injury Management	• Case Management and Injury Management activity to actively support early intervention, recovery and Return to Work and stay at work, including Claims and Injury Management strategy, Injury Management Program, Injury Management Plan, management of referrals and services to aid Return to Work and medical/injury management (including referral to icare's Medical Support Panel, if appropriate)
Complaints and internal reviews (disputes)	• Responding to and resolving customer Standard Complaints as described in Attachment 1.01 (*Claims RACI*) • Support icare to review and respond to Complex Complaints as described in Attachment 1.01 (*Claims RACI*), and External Complaints, Ministerial Complaints and escalated Complaints where required • Review and respond to internal review requests from Workers, Employers or their representatives on challenged Work Capacity decisions (including PIAWE), as described in Attachment 1.01 (*Claims RACI*) • Support icare to review and respond to internal review requests from Workers, Employers or their representatives on challenged liability decisions, as described in Attachment 1.01 (*Claims RACI*)
Administrative functions (including document management and financial administration)	• Inbound and outbound document management and record keeping • Management of aged and/or unpresented cheques • Managing payment processes (e.g., manual payments and overseas payments, invoice queries, recovery management and PAYG statements)
Claim re-opens and closure	• Closing Claims upon completion • Re-opening Claims where required • Supporting transfer of Claims to and from Other Claims Service Providers

1.2 Claims Management Services

(a) The Claims Service Provider must ensure that all Notifications and Claims are managed through a focus on recovery at work, early intervention and medical management supported by competent Case Management and at all times in accordance with the Claims Experience Standards set out in section 5.

(b) The Claims Service Provider must provide tailored Claims Management Services, taking into account:

(i) the needs of the Employer, with consideration of Employer size, industry, familiarity with the Workers Compensation Claim process and any internal processes in relation to Return to Work management;

(ii) the needs of the Worker, with consideration of Injury type and severity; occupation and psychosocial factors;

(iii) the duration and stage of the Claim; and

(iv) cohorts of Claims identified as high risk by icare, including the following types of Claims:

(A) a Primary Psychological Injury Claim where the nature of injury is in the following Type of Occurrence Classification System 3rd Edition, Revision 1, 2008, Safe Work Australia (TOOCS) codes: 702, 703, 704, 705, 706, 707, 718, 719, 910 (as updated from time to time);

(B) Additional Claims where the Mechanism of Injury is one of the TOOCS codes 81, 82, 84, 85, 86, 87, 88 and 89 (as updated from time to time);

(C) physical Injury Claims which require significant medical management. Generally, Workers with this type of injury may need significant periods of hospitalisation and prolonged assistance with daily living activities. These Claims are identified using injury coding; and

(D) where a workplace death occurs prior to Claim lodgement and circumstances where the Worker dies because of their injury during the course of the Claim.

1.3 Services to Employers and Workers

The Claims Service Provider must deliver Services to Employers and Workers in accordance with the customer engagement requirements in the Claims process as outlined in this Schedule.

1.4 Not used

1.5 icare's involvement in Claims Management

(a) The Claims Service Provider must escalate, consult with and inform icare in relation to certain Claims decisions and functions in accordance with Attachment 1.01 (*Claims RACI*).

(b) Notwithstanding icare's involvement in certain aspects of Claims Management and decision making, the Claims Service Provider will retain ongoing responsibility for the management of Claims.

1.6 Claims Estimation

(a) The Claims Service Provider must ensure that, where applicable, Claims are estimated in accordance with the approach to estimation set out in Attachment 1.02 (*Claims Estimation Manual*).

(b) The Claims Service Provider recognises that manual review and updates to Claim estimates (including Claims associated with Loss Prevention Recovery Policies) will be required from time to time, taking into account the circumstances of the Claim and in accordance with Attachment 1.02 (*Claims Estimation Manual*).

(c) Where Claims are managed on an IT system other than the Claims Technology Platform, the Claims Service Provider is responsible for maintaining an appropriate estimate of the cost of the Claim at all relevant times in accordance with Attachment 1.02 (*Claims Estimation Manual*) and taking into account the circumstances of the Claim.

(d) The Claims Service Provider must effectively communicate all Claim estimates relating to Loss Prevention Recovery Policies, including initial and material increases, to the Employer in a timely manner.

1.7 Wage Reimbursements

(a) The Claims Service Provider must pay the correct amount of weekly Benefits upon receipt of:

(i) a Certificate of Capacity; and

(ii) relevant post-injury earnings information (e.g. pay slips or other record of earnings), if the Worker is working,

within five Business Days of receiving the necessary and complete documentation.

(b) For Employers with approved Wage Reimbursement Agreements, the Claims Service Provider must ensure that each Wage Reimbursement Agreement:

(i) is only offered to an Employer that will guarantee the financial and administrative resources to make payments of weekly compensation in a timely manner and consistent with legislative requirements;

(ii) is in writing, signed by both parties and held by the Claims Service Provider in an appropriate centralised location, a copy of which must also be forwarded to icare to be kept on the underwriting file;

(iii) is reviewed annually, and the Employer must declare that reimbursements from previous periods have been claimed and no payments are outstanding;

(iv) details the procedures regarding the payment of weekly compensation to a Worker and, where applicable, any other arrangements regarding the recovery or waiving of a Claims excess;

(v) outlines the Employer's requirements regarding the forwarding of Claim documentation (including the Claim form, Certificates of Capacity, medical or legal information) and other documentation in respect of a Claim to the Claims Service Provider in accordance with the requirements specified in section 69 of the 1998 Act;

(vi) specifies that the Claims Service Provider will only reimburse the Employer for payments made in accordance with the correct weekly Benefit entitlement;

(vii) outlines the Claims Service Provider's procedures and requirements regarding the calculation of the correct Benefit entitlements and the timeliness of payments to Workers, including:

(A) the process whereby the Claims Service Provider verifies the correct Benefit entitlement;

(B) a requirement that the Employer must notify the Claims Service Provider within five Business Days when a Worker returns to work, or upgrades their hours or duties of work, so the Claims Service Provider can correctly calculate the weekly Benefit amount; and

(C) a requirement that the Claims Service Provider will notify the Employer within five Business Days of a change in the payment amount for weekly payments of compensation; and

(viii) outlines that if a Wage Reimbursement Schedule is not submitted on time for three consecutive months or if the Employer is not compliant with the requirements in section 69 of the 1998 Act:

(A) the Claims Service Provider will implement a performance management strategy with the Employer; and

(B) the Wage Reimbursement Agreement will, if the Claims Service Provider considers appropriate, be terminated and facility withdrawn if, after three months of performance management:

(1) the Employer is not submitting schedules on time;

(2) the schedules are non-compliant; or

(3) the Employer is in breach of section 69 of the 1998 Act.

(c) The Claims Service Provider must ensure that the Employer completes one Wage Reimbursement Schedule for each Worker. Each Wage Reimbursement Schedule must:

(i) be in writing;

(ii) detail the amount of the weekly Benefits to be paid to the Worker (calculated in accordance with the 1987 Act);

(iii) attach relevant pay slips;

(iv) be submitted by the Employer to the Claims Service Provider within five Business Days of the end of the monthly cycle (or a reduced cycle, as negotiated with the Claims Service Provider); and

(v) provide that the Claims Service Provider will reimburse the Employer within 15 Business Days of receipt of a complying Wage Reimbursement Schedule, subject to normal claims administration requirements (including whether the claim has been accepted or provisionally accepted and whether Certificates of Capacity have been provided).

(d) If a Wage Reimbursement Schedule is not received from the Employer within the timeframe specified in accordance with section 1.7(c)(iv), the Claims Service Provider must document all attempts to obtain the required information from the Employer in order to process timely and accurately weekly payments.

1.8 Utilisation and management of Third Party Service Providers

The Claims Service Provider must:

(a) in managing Third Party Service Providers:

(i) promptly issue appropriate referrals, advice and instructions to Third Party Service Providers, in each case as appropriate to the circumstances and needs of the injured Worker concerned;

(ii) approve initial or ongoing intervention for Claims, in accordance with Attachment 1.03 (*Treatment Decision Making Framework*) and based on sufficient information to enable the application of:

(A) the principles of reasonably necessary intervention; and

(B) the intervention contributing to recovery at work, increased capacity for work, and/or other Claims outcomes;

(iii) proactively check each health practitioner's registration status prior to engagement and payment;

(iv) document all decisions regarding Claim intervention and management, identifying the objective, expected duration and cost of each Third Party Service Provider's services related to such Claim, or the reason for non-documentation being undertaken (to the extent that such intervention is within the prescribed parameters as detailed in the Schedules or Manuals); and

(v) not outsource Claims decisions to legal Third Party Service Providers;

(b) use best endeavours to ensure that Third Party Service Providers comply with the terms of their contracts with icare or the Claims Service Provider (where applicable) and all requirements applicable under Law and regulatory requirements (including SIRA requirements), including:

(i) that legal Third Party Service Providers act as a model litigant on behalf of icare;

(ii) that all requests for services from legal Third Party Service Providers are:

(A) created and actioned through icare's legal matter management platform (which is known as the Legal Panel Gateway as at the Commencement Date) or, if applicable, any updated or alternative system that may be implemented during the Term;

(B) appropriate and legal costs are managed;

(iii) by regularly monitoring intervention, with a view to ensuring Third Party Service Providers are committed to, and take responsibility for, the outcomes of their intervention; and

(c) without limiting sections (a) to (b), comply with the requirements below when working with Third Party Service Providers:

Practice elements	Sub-elements	Key expectations and requirements
Engagement of Third Party Service	Third Party Service Provider selection	The Claims Service Provider may only engage Third Party Service Providers that are not contracted by icare in the following circumstances:

Practice elements	Sub-elements	Key expectations and requirements
Providers (referral)		• if the services required are not within the scope of any Third Party Service Provider's contract with icare; • if the Third Party Service Providers contracted by icare are not able to perform the required services in the geographical location where the services are required; • if in the case of workplace rehabilitation service providers only, the Worker or Employer makes a request for use of a Third Party Service Provider that is appropriately accredited or otherwise approved by SIRA and is not contracted by icare. The Worker's preference is to be given priority over the Employer's in the event of any conflicting requests; or • if otherwise instructed by icare.
	Service selection	The Claims Service Provider must ensure that the services being requested are: • in line with claims and customer needs; • reasonably necessary; • requested in accordance with icare contracts (where applicable); and • permitted to be provided under Law and Regulatory Guidance, including SIRA requirements.
Funding	Approval	The Claims Service Provider must ensure that the funding of Third Party Service Provider services is approved in accordance with: • any relevant icare fees schedule/s (where available); and • any relevant SIRA regulated fees (where icare does not have fees schedules). Where the above do not apply, the approved funding must be at reasonably appropriate rates (including as required under section 60 of the 1987 Act, where applicable).
	Payments	The Claims Service Provider must ensure that payments to Third Party Service Providers are: • made in accordance with clauses 14 (Third Party SP Payments) and 28.5 (Prescribed fee and fee must be reasonable if not prescribed) of the Contract Terms and made in accordance with prior approvals (where applicable); • timely (adherent to SIRA and ATO requirements); and • reasonably appropriate and for reasonably necessary services.
Service utilisation	While the services are being	The Claims Service Provider must:

Practice elements	Sub-elements	Key expectations and requirements
	performed by the Third Party Service Providers	• establish and maintain regular contact with Third Party Service Providers; • use best endeavours to ensure that each Third Party Service Provider performs the services in accordance with the expectations established and requirements set out in the Third Party Service Provider's contract with icare or the Claims Service Provider (where applicable); • use best endeavours to ensure that each Third Party Service Provider performs the services in compliance with Law and regulatory requirements (including SIRA requirements); • monitor service costs and billing practices regularly; and • ensure that it provides feedback to Third Party Service Providers in relation to service quality and customer experience as appropriate.
Third Party Service Provider management	Performance & spend	The Claims Service Provider must: • monitor Third Party Service Providers' performance, utilisation, spend and outcomes achieved on a regular basis and support improvement where possible; • for Third Party Service Providers contracted by icare (including by the Claims Service Provider as icare's agent), provide reporting in accordance with Schedule 3 (Performance Management and Governance) and as requested by icare from time to time and regular feedback on Third Party Service Providers' performance, utilisation, spend and outcomes achieved relevant to the Claims Service Provider's claims portfolio; • for Third Party Service Providers contracted by icare (including by the Claims Service Provider as icare's agent), regularly and actively manage Third Party Service Providers' performance and spend to maximise value to the Scheme and customers; and • for Third Party Service Providers contracted by icare (including by the Claims Service Provider as icare's agent), notify icare of any contractual breaches by the Third Party Service Provider or any other conduct or practice patterns that warrant escalation to icare, and any steps that the Claims Service Provider proposes to take to enforce icare's rights against the Third Party Service Provider.

1.9 Managing Claim Handovers and transferring Claims

The Claims Service Provider must:

(a) ensure continuity of care and effective Claim Handover when there is a temporary or permanent change in the Claim ownership (any change from team-based to individual

Claim ownership, in accordance with the Claims Service Provider's Approved cohort management approach), including by:

(i) ensuring that a review of the whole Claim, current claims strategy and Injury Management Plan occurs at the time of the Claim Handover;

(ii) promptly following through on any urgent actions;

(iii) assigning Claims to a suitably competent Case Manager or Claims team, depending on the needs of the Claim and the Approved cohort management approach; and

(iv) ensuring that the Case Manager or team receiving the Claim makes timely contact with the Employer, Worker and other Key Parties to notify and establish working relationships, taking into account the circumstances of the Claim and reason for transfer; and

(b) for transferring Claims on the Claims Technology Platform between the Claims Service Provider and Other Claims Service Providers, comply with Schedule 7 (*Claims File Transfer*) and any additional steps as specified by icare from time to time.

1.10 Shared Claims and Concurrent Claims

The Claims Service Provider must:

(a) manage shared and concurrent Claims as required by icare from time to time;

(b) work collaboratively to ensure that the Worker is not disadvantaged and that focus remains on facilitating the Worker's recovery and Return to Work; and

(c) promptly notify icare of any:

(i) dispute or disagreement regarding whether the Claims Service Provider, Other Claims Service Provider or insurer should manage the Claim or how those Claims should be or are apportioned;

(ii) litigation that involves Other Claims Service Providers or another insurer and the Claims Service Provider; and

(iii) disagreement between the Claims Service Provider and any Other Claims Service Providers or insurer as to who will be the lead agent instructing on a particular matter or which law firm will represent all relevant interests in proceedings.

1.11 Employer capabilities to prevent Injury and improve recovery at work outcomes

The Claims Service Provider must:

(a) establish an Injury Management Program in accordance with section 43 of the 1998 Act and provide a copy to icare as per the frequency set out in Attachment 3.05 ("Reports Matrix");

(b) provide education and information to each Employer with a Claim managed by the Claims Service Provider (in each case, in a form and at a frequency required to support the Employer's understanding of its obligations in the Claim process), including:

(i) the Employer's obligations with regard to:

(A) Notification;

(B) Return to Work (offer of Suitable Employment); and

(C) Injury Management;

(ii) the physical, social and financial Benefits of work and recovery at work;

(iii) a copy of the Claims Service Provider's Injury Management Program;

(c) promote and encourage Employers to:

(i) remain engaged, proactive and supportive of each Worker when a Claim is made; and

(ii) offer Suitable Employment to each Worker; and

(iii) act in accordance with their obligations under the 1987 Act and 1998 Act;

(d) identify and escalate to icare, Employers with a consistently poor Claims or Return to Work record or practices, and undertake targeted actions and initiatives to improve the Employer's Return to Work record or practices;

(e) in collaboration with each Employer, develop strategies tailored to the size of Employer's business (Small Employer, Medium Employer and Large Employer) that can reduce Claim costs and improve recovery at work outcomes through the promotion of recovery at work; and

(f) recover a claims excess for applicable Claims in accordance with the 1987 Act.

1.12 Employer Obligations

The Claims Service Provider must:

(a) take reasonable steps to inform Employers of their legislative obligations, particularly their obligation to provide suitable opportunities for Workers to recover at work through Suitable Employment;

(b) notify icare of any Employers that are not meeting their legislative obligations within three Business Days of becoming aware of such non-compliance to the extent it becomes aware of any non-compliance by an Employer of its legislative obligations; and

(c) work collaboratively with icare by providing reasonable assistance on request to the Employers to rectify such non-compliance.

1.13 Prescribed forms and correspondence

(a) The Claims Service Provider must use the forms and correspondence templates provided by icare or as otherwise prescribed by the regulations or guidelines, unless instructed otherwise by icare.

(b) The Claims Service Provider must submit any proposal to use non-standardised forms to icare for Approval before using them.

1.14 Data accuracy and integrity

(a) The Claims Service Provider is responsible for ensuring all Data relating to Claims is current and accurate.

(b) Subject to section 1.14(c), the Claims Service Provider is responsible for undertaking remediation of incorrect Data relating to Claims, including:

(i) the timely remediation of suspect and fatal errors identified through data submission processes to SIRA and within the timeframes specified by SIRA; and

(ii) remediation of the Data as required by icare from time to time.

(c) If the Claims Service Provider can establish to icare's reasonable satisfaction that:

(i) there are material inaccuracies in Data relating to Claims that have been transferred from an Other Claims Service Provider to the Claims Service Provider (**Legacy Data**);

(ii) material effort is required to correct the Legacy Data in excess of what would reasonably be considered to be business as usual activities;

(iii) the inaccuracies in the Legacy Data were present when the relevant Claims were transferred to the Claims Service Provider; and

(iv) the Claims Service Provider has taken all reasonable steps to confirm the accuracy of the Legacy Data when the Claims are transferred to the Claims Service Provider and has promptly notified icare on becoming aware of the inaccuracies,

then:

(v) the Claims Service Provider must reasonably assist icare to enforce icare's rights against the Other Claims Service Provider in relation to remediation of the Legacy Data; and

(vi) the Claims Service Provider will not be required to carry out remediation of the Legacy Data under section 1.14(b) in excess of what would reasonably be considered to be business as usual activities unless icare Directs the Claims Service Provider to do so, such Direction to be considered a Chargeable Direction.

(d) Nothing in section 1.14(c) relieves the Claims Service Provider from any obligation to remediate Data (including Legacy Data) under any other provision or requirement of the Contract or other agreement or arrangement between the parties, for example under any agreed data migration project.

1.15 General requirements - information and Records management

The Claims Service Provider must ensure that records are created, captured, protected and disposed of according to the requirements detailed in Schedule 8 (*Information Security and Management*) and SIRA's Insurer Claims Management Audit Guide.

2. Management of Claims on the Claims Technology Platform

2.1 Claims to be managed on icare's Claims Technology Platform

(a) The Claims Service Provider must manage all new Claim lodgements and existing Claims on the Claims Technology Platform unless otherwise instructed or permitted by icare.

(b) The Claims Service Provider is responsible for following a system incident reporting procedure to escalate system incidents to icare for management and resolution in accordance with the Service Desk Support Model in Schedule 9 *(Claims Technology Platform*).

(c) The Claims Service Provider is responsible for ensuring Personnel are competent in managing Claims via the Claims Technology Platform. The Claims Service Provider may

request that icare provide it with relevant Claims Technology Platform training content from time to time.

(d) Subject to section 2.1(e), icare is responsible for data submissions to SIRA for Claims on the Claims Technology Platform.

(e) The Claims Service Provider is responsible for data submissions to SIRA for any Claims managed on an IT system other than the Claims Technology Platform.

2.2 Administrative functions

(a) Claims Service Provider responsibilities

(i) The Claims Service Provider must perform Document management and other Claims administration functions in relation to Claims managed on the Claims Technology Platform. This includes:

(A) inbound and outbound Document management (except as specified in section 2.2(a)(ii));

(B) management of aged unpresented cheques;

(C) initiation and management of recovery of Benefits wrongly paid;

(D) overseas payments through established manual payment processes; and

(E) support in customer enquiries and requests for provision or copies of PAYG statements.

(ii) The Claims Service Provider is responsible for utilising outputs of icare's Triage engine to assist with management of Claims.

(b) Responsibilities of icare

(i) icare must provide administration support including:

(A) managing unscannable postal mail (including returned cheques and police report distribution);

(B) managing inbound Documents where the Claims Service Provider cannot be identified;

(C) blocking and unblocking of Third Party Service Providers or other vendors as instructed by icare delegates;

(D) supporting the transfer of Claims between the Claims Service Provider and Other Claims Service Providers on the Claims Technology Platform; and

(E) complex Policy verification for Injury notifications lodged through the Claims Technology Platform without a valid policy number.

3. Branding and use of Claims Service Provider trading name

(a) When dealing with any person other than icare in connection with the Services, the Claims Service Provider must include its trading name, ABN and state that it is acting as agent for icare on at least:

(i) its bank accounts;

(ii) Tax Invoices or documents that will be a Tax Invoice when paid;

(iii) forms related to Claims Management;

(iv) the Claims Service Provider's letterhead (when used in relation to this Contract);

(v) remittance advice; and

(vi) email correspondence relating to Claims Management.

(b) The Claims Service Provider must use artwork provided by icare on all forms related to Claims Management.

(c) The Claims Service Provider may elect to use its trading name for other documents, such as its website, business cards and presentation templates.

(d) Any standard letters and other documents provided by icare, or automatically generated by the Claims Technology Platform, must display 'dual branding,' including the trading name of icare and the Claims Service Provider.

4. Capability

4.1 General requirements

(a) Core competencies are essential elements of the Contract and are required to support the delivery of the Services.

(b) The core competencies for the provision of Claims Management Services are the requirements and standards described in this section 4.

(c) The Claims Service Provider must work with icare to deliver the capability and competency frameworks set out in section 4.2(a) for all of the Claims Service Provider's Personnel involved in the management of Claims.

(d) The Claims Service Provider must have sufficient competent Personnel as set out in this section 4 in order to effectively manage its Claims and tailor end-to-end Claims Management Services that meet the needs of Employers and Workers and adopt an Approved cohort management approach.

4.2 Competency of the Claims Service Provider and Personnel

The Claims Service Provider must:

(a) develop, maintain, align and comply with any capability, competency frameworks or standards set out in Attachment 1.04 (*Professional Standards Framework*) and Attachment 1.03 (*Treatment Decision Making Framework*) that identifies required competencies for Personnel providing Claims Management Services as updated or amended from time to time;

(b) recruit Personnel with the appropriate competencies in accordance with the Professional Standards Framework in Attachment 1.04 and other relevant industry standards. The Claims Service Provider will commit to ensuring that appropriate training, career and accreditation paths and support will be provided to support sustainable tenure and a fair and reasonable ability for Personnel to meet the Professional Standards Framework. If the Claims Service Provider does not recruit Personnel in accordance with any aspect of the Professional Standards Framework, then the Claims Service Provider must notify icare when any such recruitment is underway, and where requested by icare, provide icare with a

plan that seeks to address any associated skill gaps required for the recruits to meet relevant aspects of the Professional Standards Framework;

(c) ensure that the appropriate Personnel are trained and competent in the Claims Service Provider's and icare's relevant frameworks, models and methodologies required in accordance with or to comply with Best Industry Practice (including the Professional Standards Framework), and as required to deliver the Services;

(d) demonstrate commitment to building capability of Personnel by identifying training needs for each employee role and developing associated training (as required). This includes mandatory participation in a learning governance or other forum established by icare where learning offerings and randomised assessment samples will be moderated. Learning offerings will be provided for review to ensure congruence with the Professional Standards Framework, and the availability of the Claims Service Provider's learning materials for icare to review and provide feedback on. The parties agree that any learning materials developed by the Claims Service Provider under this section 4 will not be Foreground Material, but rather will be treated as Claims Service Provider Material, and that the licence granted to icare under clause 33.2(a) of the Contract Terms in respect of these learning materials will not be sublicensable to Other Claims Service Providers and will be limited to the purposes of review and providing feedback;

(e) ensure that competencies and skills of Personnel are kept up to date by ensuring that ongoing training is provided to them, in order to retain and enhance skills to meet evolving business needs. This may include mandatory training defined by the Standards Framework, learning pathways, utilisation of learning material and offerings or attendance of training arranged or facilitated by icare;

(f) develop and provide icare with a copy of the Claims Service Provider's capability uplift plan, which details all training scheduled to comply with the requirements of the Contract including mandatory training, capability uplift programs, inductions and onboarding, legislative requirements and training defined by the Standards Framework. The capability uplift plan is to be submitted as part of the Annual Business Plan to be delivered in accordance with Schedule 3 (*Performance Management & Governance*) and reported on quarterly;

(g) upon icare's request, complete a baseline competency assessment to assess the competencies and skills of Personnel using the standardised scoring methodologies and tools as provided by icare. icare and the Claims Service Provider will use the results of the baseline assessment as the first data marker for the purposes of subsequent reporting. The Claims Service Provider must report on the competencies and skills of Personnel in accordance with the performance reporting framework set out in Schedule 3 (*Performance Management & Governance*) and Attachment 3.05 (*Reports Matrix*);

(h) unless otherwise Approved by icare, utilise and administer learning platforms and/or learning management systems as required by icare;

(i) provide training records, including attendance and completion reports to icare in accordance with Schedule 3 (*Performance Management & Governance*) and Attachment 3.05 (*Reports Matrix*). As a minimum this will include details of the training provided and the percentage of staff that attended, completed, and is still to complete the training (summarised by role);

(j) manage performance of employees, including by encouraging open and honest communication between employees and their managers about performance against defined capabilities and performance indicators promoting consistency, equity and transparency; and

(k) in conjunction with icare, plan and review the level of Personnel required to meet current and future organisational needs in accordance with the Annual Business Plan to be delivered in accordance with Schedule 3 (*Performance Management & Governance*).

4.3 Case Manager specific competencies

The Claims Service Provider must develop and integrate the Claims Experience Standards, as set out in section 5, into Case Managers' delivery of Claims Management Services. The Claims Service Provider must ensure that Case Managers have the following competencies:

(a) Guidance and accessibility

Case Managers are expected to ensure that Workers, Employers and other Key Parties are provided with regular, timely and clear information about the Claim and must:

(i) clearly communicate with Workers and Employers at the outset of a Claim, and regularly throughout the Claim;

(ii) actively promote the benefits of recovery at work and Return to Work; and

(iii) provide information at an appropriate time in ways that are useful and accessible to the audience.

(b) Empathy and proactivity

Case Managers are expected to develop a holistic understanding of the needs of Workers and Employers, responding to these consistently and empathetically. This must be demonstrated through:

(i) a tailored approach to Claims Management, based on the needs of Workers and Employers, which takes into account their unique needs, context and the relationships; and

(ii) being responsive to changes in Workers' and Employers' needs and adapting quickly.

(c) Accountability and transparency

Case Managers are expected to demonstrate transparency and accountability of actions through collaboration, in particular by:

(i) being honest and transparent in every interaction;

(ii) consulting with Employers and Workers early and regularly throughout the life of the Claim;

(iii) delivering on commitments made to Workers, Employers and Key Parties; and

(iv) collaborating with Workers and Employers and other Key Parties to facilitate recovery at work and Return to Work wherever possible.

(d) Fairness and empowerment

Case Managers are expected to facilitate fair, evidence-based decisions, in particular by:

(i) considering all available information to make a soundly-based decision;

(ii) communicating regularly and on a timely basis, ensuring that the rationale for decisions and outcomes are clearly explained; and

(iii) providing clear escalation pathways when things go wrong and resolving concerns quickly.

(e) Ease and efficiency

Case Managers are expected to seek efficiency in processes and operations to help make the complex simple, in particular by:

(i) contributing ideas to improve systems and processes;

(ii) setting clear expectations with Workers, Employers and other Key Parties and keeping them updated as things progress; and

(iii) anticipating the needs of Workers and Employers, and taking action when needed.

5. Claims Experience Standards

The set of standards below have been established to support the design and delivery of the Services and may be amended or updated from time to time by, or on instruction from, icare. These standards are anchored to the SIRA Customer Service Conduct Principles and aligned with the NSW Government Customer Commitments. They are designed to support Return to Work and health outcomes.

Injured Worker & Employer needs	Guidance & accessibility	Empathy & proactivity	Accountability & transparency	Fairness & empowerment	Ease & efficiency
Our commitments to injured Workers & Employers (Claims principles)	**Guide me** We enable access and clarity of information for injured Workers, Employers and relevant parties...	**Understand me** We understand the holistic needs of injured Workers and Employers, responding to these consistently and empathetically ...	**Collaborate with me** We enable transparency and accountability of actions through collaboration ...	**Help me move forward** We facilitate fair, evidence-based decision making...	**Value my time** We continually seek efficiency in our processes and operations to help make the complex simple...
Outcomes for injured Workers & Employers	...so that injured Workers and Employers can confidently navigate the process.	...so that injured workers and employers feel understood and acknowledged.	...so that all parties are clear about their role and obligations.	...so that injured Workers and Employers can focus on moving forward.	...so that injured Worker and Employer experiences reflect the value we place on their time and resources.
Customer Service Conduct Principles	Be accountable for actions and honest	Act fairly, with empathy and respect.	Resolve customer concerns quickly,	Have systems in place to identify and	Be efficient and easy to engage with.

Injured Worker & Employer needs	Guidance & accessibility	Empathy & proactivity	Accountability & transparency	Fairness & empowerment	Ease & efficiency
	in interactions with customers.		respect customers' time and be proactive.	address customer concerns.	

5.1 Customer engagement

(a) The Claims Service Provider is required to develop and maintain customer engagement through appropriate communication between the Claims Service Provider and Workers, Employers and other stakeholders in the Scheme (collectively "**Stakeholders**"). This communication can be a reaction, interaction, effect or overall experience which can happen online and offline.

(b) Customer engagement is intended to increase confidence and trust in Stakeholder interactions and support the Scheme Principles.

(c) An important aspect of customer engagement is to ensure the provision of equal access to Services for all members of the NSW community including customers experiencing vulnerability due to disability or any other factor. It is vital that Claims Service Provider Personnel in customer contact roles understand and are provided with appropriate training to uphold the principles of:

(i) diversity and inclusion;

(ii) equal employment opportunity;

(iii) ethical practice;

(iv) customer service; and

(v) workplace health and safety.

(d) The Claims Service Provider must ensure that adverse decisions or Complaint outcomes are communicated to each Stakeholder with empathy and adopt an approach that respects differences in cultural, socio-economic and religious backgrounds. This may include arranging a face-to-face meeting or speaking to the Stakeholder on the telephone prior to sending the information in a letter or email.

(e) The Claims Service Provider will endeavour to keep the connection and communication channels open and functioning between the Employer and the Worker (where reasonably practical). Where there is an issue doing so in a reasonably practical manner, the Claims Service Provider must advise the Employer that there will be no further communication and the reasons for ceasing communication.

(f) When communicating the outcome of a decision, dispute or review to the Worker, the Employer and other Stakeholders as relevant, the basis for the decision should be referenced to legislation, regulations and the Claims Service Provider's policies, procedures or processes.

(g) Correspondence must be written in plain English with an interpretation or explanation of the legislation to maximise the likelihood that the information is clearly understood by the Stakeholder.

(h) All customer service interactions are to be provided free from all forms of bias, discrimination, bullying and harassment, and ensure respect and fairness to Stakeholders.

5.2 Customers experiencing vulnerability

(a) The Claims Service Provider must identify when customers experience vulnerability, review their circumstances and respond with appropriate special care and additional assistance as required. Vulnerability may occur either as a result of a Claim or separately from a Claim (e.g., pre-existing disability, social disadvantage or homelessness).

(b) The Claims Service Provider must obtain a customer's consent to record any vulnerable circumstances, even where that information will be used solely to provide the customer with special care and additional assistance.

(c) The Claims Service Provider must address vulnerability appropriately and provide options, which could include:

(i) helping to lodge a Complaint or complete a form;

(ii) providing translation or interpreting services;

(iii) engaging a support person such as a family member;

(iv) adapting communication when it is apparent that a specific communication requirement is needed;

(v) utilising resources to assist with adaptive communication, such as:

(A) translation and interpreting services: ATL www.atl.com.au;

(B) Deaf Society NSW website for interpreters: http://deafsocietynsw.org.au;

(C) Vision Australia website for adaptive resources: http://visionaustralia.org; and

(D) National Relay Service: https://www.infrastructure.gov.au/media-communications-arts/phone/services-people-disability/accesshub/national-relay-service;

(vi) referral to Claims Support Services or advocacy services for additional support outside of the workers compensation claims process; and

(vii) other individualised approaches as the Claims Service Provider or icare considers appropriate in the circumstances contemplated in the Claims RACI.

5.3 Customer Service Model

(a) The Claims Service Provider is required to develop and implement a Customer Service Model and associated policies, procedures and processes that meet the following requirements:

(i) icare's Claims Experience Standards, set out in section 5;

(ii) icare's Complaints requirements as set out in section 10.1 ;

(iii) Performance Measures and Applicable Standards; and

(iv) the requirements set out in section 5.3(b).

(b) Without limiting section 5.3(a), the Claims Service Provider's Customer Service Model must:

(i) depict the standard of service that customers can expect, outline details of key stakeholders and customers, provide information on how to lodge a Complaint and

include service standards (such as expected timeframes for response and resolution, including any of those required by Performance Measures and Applicable Standards);

(ii) offer customers a variety of options to contact the Claims Service Provider, including telephone, website/online, face-to-face and clearly outline roles and responsibilities at each stage of a customer's interaction with the Claims Service Provider;

(iii) be published on the Claims Service Provider's website and be provided to customers along with other relevant information at the commencement of a Claim;

(iv) adhere to the NSW Government guidelines provided to the Claims Service Provider by icare that outline the standards of professionalism, behaviour and ethics expected of Personnel managing customer interactions as set out in section 5.4;

(v) establish processes and procedures to regularly document evidence of the Claims Service Provider's compliance with the SIRA Customer Service Conduct Principles and make this evidence available to icare on request within a reasonable amount of time;

(vi) establish processes and procedures for continuous improvement to enable ongoing analysis of customer data to identify customer experience and process improvements and resolve Issues; and

(vii) provide timely and accurate data to icare for the periodic measurement of customer experience through icare's customer experience measurement program described in section 6.1(a), monitoring and oversight of the Customer Service Model including Complaints handling or for general research purposes. Data might include recorded feedback that is received via telephone calls to a contact centre, online chat logs or other data sources relating to customer experience and satisfaction. The Claims Experience Standards will form the basis of customer experience measurement.

(c) The Claims Service Provider must have in place a process to support the health, safety and wellbeing of Personnel while at work that ensures the risk of customer behaviours impacting Personnel is identified and managed. Mechanisms to support this requirement could include the provision of counselling and debriefing services to Personnel who have been impacted.

5.4 Behaviour

(a) Overview

The Claims Service Provider must:

(i) demonstrate behaviour that upholds icare values as set out in Schedule 3 (*Performance Management & Governance*);

(ii) comply with the customer service conduct principles as set out by SIRA;

(iii) ensure its Personnel have the training, skills and experience they need to provide quality and culturally sensitive Services to customers;

(iv) handle all matters including Complaints, enquiries and requests for information consistently, promptly and fairly, in a non-discriminatory way and in accordance with applicable standards and processes Approved by icare;

(v) behave ethically and not bully, discriminate against, harass, intimidate, victimise or vilify any person during the course of providing the Services;

(vi) speak up and report misconduct, discrimination, bullying, harassment and incidents;

(vii) treat every customer fairly and with respect;

(viii) be open and accountable;

(ix) ensure there is no improper use of information, technology or resources; and

(x) avoid any practice or activity which could bring themselves, icare or the Scheme into disrepute.

(b) Honesty and integrity

The Claims Service Provider must act with honesty and integrity at all times in the provision of the Services. This includes:

(i) acting in good faith and for the benefit of the Scheme. Where this obligation conflicts with another duty of the Claims Service Provider or its commercial interests, then this obligation and the interests of the Scheme will prevail to the extent of the conflict;

(ii) advising icare of any potential Conflicts as soon as possible after the potential Conflict is known; and

(iii) employing business ethics policies that are similar to, and reflect the intent of, those policies to which icare adheres which include:

(A) no solicitation of bribes, gifts or benefits or behaving in a manner that could be seen to represent this behaviour. This includes attending lunches, dinners, parties and sporting events as a guest of providers;

(B) not accepting receipt of a gift, favour or benefit in excess of a value of $50; and

(C) not accepting monetary gifts.

(c) Professional behaviour

The Claims Service Provider must ensure its Personnel:

(i) present to work in a condition that renders them capable of safely carrying out their duties and responsibilities;

(ii) do not undertake any work, including driving work vehicles, if they are under the influence of any alcohol or drug (including prescription drugs) that could impact their ability to properly complete their duties or pose a risk to themselves or others. The Claims Service Provider must implement and maintain appropriate drug and alcohol policies; and

(iii) do not carry out, and are not otherwise involved in, any of the following:

(A) any illegal, unethical or dishonest conduct;

(B) participating in, accessing or disseminating offensive or inappropriate material;

(C) fraud or misrepresentation, including misrepresentation of identity including origination of messages (including spamming, spoofing or use of other identities akin to identity theft).

6. Customer experience measurement

6.1 General

(a) Customer experience will be measured and reported on through icare's Customer Experience Measurement Program. A number of different measures are used to understand customer experience and service delivery of the Claims Experience Standards.

(b) The Claims Service Provider must review and use customer feedback captured in the Customer Experience Measurement Program to enhance customer understanding and to help drive continuous improvement in its operations.

6.2 Service Recovery Tickets

(a) A service recovery ticket is an automatic workflow (email) generated by the Customer Experience Measurement Program in response to negative feedback from a customer who has provided explicit permission to be contacted.

(b) The Claims Service Provider is accountable for the service recovery tickets allocated to them by the Customer Experience Measurement Program.

(c) The Claims Service Provider is expected to close a service recovery ticket within seven Calendar Days. The Claims Service Provider must try and resolve the issue to the best of its ability and summarise any actions or decisions on the ticket in the Customer Experience Measurement Program.

6.3 Urgent Action Ticket

(a) An urgent action ticket can be generated by the Customer Experience Measurement Program in response to customer feedback where it is reasonable to believe that the survey respondent may be at risk of self-harm or harm to others.

(b) The Claims Service Provider is accountable for the urgent actions allocated to them by icare.

(c) The Claims Service Provider must make contact with the survey respondent associated with an urgent action on the same day or within 24 hours of being notified of it. The Claims Service Provider's priority must be to confirm the wellbeing of the survey respondent who provided the feedback.

(d) The Claims Service Provider must use its best endeavours to resolve the urgent action.

(e) icare's Sensitive Claims team may liaise with the Claims Service Provider to support the management and resolution of an urgent action.

(f) The Claims Service Provider must summarise any actions or decisions in the urgent action ticket on the Customer Experience Measurement Program.

7. Litigation policy

7.1 Model Litigant Policy

(a) icare is obliged to conduct itself as a model litigant in the conduct of all litigation involving icare, including litigation before courts, tribunals and inquiries and other alternative dispute

resolution processes, in accordance with the New South Wales Government's Model Litigant Policy for Civil Litigation (**"Model Litigant Policy"**). The Claims Service Provider must act consistently with that policy when engaging and instructing legal Third Party Service Providers on behalf of icare.

(b) The Claims Service Provider must maintain high quality disputes and litigation expertise through Key Personnel with suitable experience and expertise to ensure decision makers act consistently with the Model Litigant Policy.

(c) The Claims Service Provider must promptly report to icare any issues relating to its or its legal Third Party Service Providers' non-compliance with the New South Wales Government's Model Litigant Policy.

7.2 Service Delivery

(a) The Claims Service Provider must always manage litigation in accordance with best practice, including strict compliance with the relevant legislation, policies and practice directions as required.

(b) The Claims Service Provider must use icare's legal management system (which is known as Legal Panel Gateway as at the Commencement Date) to procure all legal services in connection with the conduct of litigation (including threatened or proposed litigation).

(c) The Claims Service Provider must ensure that all advices, pleadings and other relevant documents received via icare's legal management system are uploaded to icare's Claims Technology Platform.

(d) The Claims Service Provider must ensure timeliness of communication on the litigation process with impacted Employers, including what to expect through the process and relaying information in a way and at a time that makes sense to them.

(e) The Claims Service Provider must demonstrate adherence to any approved budget for legal spend.

(f) The Claims Service Provider must ensure all legal services provided are accurately charged for and paid.

7.3 Reporting on Significant legal issues

(a) The Claims Service Provider must report to icare any Significant legal issues that arise in the provision of legal services or in the conduct of litigation (including threatened or proposed litigation) within five Business Days of becoming aware of that issue. A notice under this section 7.3(a) must be made in writing and sent to icare's Significant Legal Matters Mailbox (SLM@icare.nsw.gov.au) in the Approved form (or as notified by icare to the Claims Service Provider from time to time).

(b) For the purposes of section 7.3(a), a matter will involve a Significant legal issue if a litigation or potential litigation:

(i) raises any issue that is fundamental to the responsibilities of icare or another NSW Government Agency, including matters that involve Significant operational, ethical, policy, industrial, occupational health and safety issues, intergovernmental relations, arrangements or agreements;

(ii) relates to the fatality of a Worker or any other matter that may attract or does attract media attention;

(iii) is listed for more than five hearing days;

(iv) involves the actual or proposed use of Senior Counsel;

(v) involves any appeal in any jurisdiction on a substantive legal or constitutional issue;

(vi) involves bankruptcy proceedings brought as a result of a claim for debt recovery;

(vii) is likely to result in damages or a penalty of $1,000,000 or more;

(viii) seeks to challenge the validity of the Contract, including the Schedules to the Contract or the Manuals or is factually complex (for example, involves multiple parties);

(ix) involves questions of statutory interpretation of the Workers Compensation legislative scheme, in which arguments are made about the intention of the provisions of that scheme; or

(x) is any other type of matter that icare advises is Significant.

7.4 Management of Significant legal issues

(a) The Claims Service Provider is responsible for the management of litigation and icare is responsible for the strategy and oversight of all Significant legal issues.

(b) The Claims Service Provider must comply with any instructions provided by icare on the conduct of litigation involving Significant legal issues. In particular, the Claims Service Provider must comply with any instructions from icare to provide copies of, or access to, information about a particular Claim or litigation and any instructions as to the manner in which the litigation must be managed. For Significant legal issues, this may include selecting the legal Third Party Service Provider and counsel to be engaged to provide services, and the legal Third Party Service Provider accepting day-to-day instructions in relation to the matter from icare only.

(c) icare instructions to the Claims Service Provider in respect of current or potential litigation involving a Significant legal issue must be issued by the Group Executive, Workers Compensation or their delegate on behalf of icare.

7.5 Claims and Litigation by or against icare or Other Claims Service Providers

(a) The Claims Service Provider must promptly inform icare of any claim or litigation proposed to be brought against, or involving, icare or any Other Claims Service Provider.

(b) The Claims Service Provider must comply with any instructions issued by icare on the handling of claims and the conduct of any litigation brought against, or involving, icare or any Other Claims Service Provider (whether a Significant legal issue under section 7.3(b) or otherwise). In particular, the Claims Service Provider is to comply with any instruction to provide information about a particular claim or litigation, or to provide copies of, or access to, material relating to the claim or litigation issued by the Group Executive, Workers Compensation or their delegate on behalf of icare.

(c) Monetary claims against icare or the Claims Service Provider in its capacity as agent for icare (other than claims that are to be determined under a legislative or contractual mechanism) must be managed by the Claims Service Provider in accordance with all applicable Laws and this Contract.

7.6 Public Interest Immunity

(a) If a request or Demand to provide documents or information in the conduct of litigation for which the Claims Service Provider has administrative responsibility may give rise to a claim of immunity on a public interest ground, the Claims Service Provider must refer the question of whether to make the claim to icare.

(b) If a claim for public interest immunity is being resisted by another party in litigation, the Claims Service Provider must refer the claim to icare. If a disagreement arises as to the handling of the claim, the matter is to be determined by icare.

7.7 Disputes Involving 'State of Connection'

If ambiguity or a dispute arises in regard to a 'state of connection' determination pursuant to section 9AA of the 1987 Act, the Claims Service Provider must escalate the matter to icare's designated email address for instruction.

7.8 Claims Service Providers participation and attendance at in-person dispute resolution events

(a) Claims Service Providers must meet all applicable timetables, rules, practice directions and procedures of the Personal Injury Commission.

(b) Where a Personal Injury Commission venue is an in-person hearing or mediation, the Claims Service Provider must ensure that a person with knowledge of the relevant claim and who holds the necessary delegation to provide timely and appropriate instructions participates and attends in person unless excused.

8. icare's Confidential Information

When considering the disclosure of Confidential Information, the Claims Service Provider must comply with the requirements described below as well as any requirements prescribed in relevant Law.

8.1 Release of Information to Workers

(a) Subject to legal professional privilege and unless instructed otherwise by icare, the Claims Service Provider must release to Workers on request any Document that forms a part of their Claims Record, including:

(i) treating and independent medical reports;

(ii) factual and surveillance reports;

(iii) Injury Management reports;

(iv) Work Capacity Assessments;

(v) Wages information; and

(vi) recorded telephone conversations between the Claims Service Provider and the Worker.

(b) Where the Claims Service Provider forms the opinion that the release of this information would pose a serious threat to the life or health of a Worker or any other person, they

should disclose the information to a medical practitioner or a legal practitioner where permitted, in accordance with clause 41(5) of the Workers Compensation Regulation 2016 (NSW).

(c) If the Claims Service Provider is unsure as to whether it should or is permitted to disclose icare Confidential Information, the Claims Service Provider should seek instructions from icare regarding the release of the information from icare.

(d) The Claims Service Provider should make its application for instructions under section 8.1(c) in writing to icare's Significant Legal Matters Mailbox (SLM@icare.nsw.gov.au or as otherwise notified by icare to the Claims Service Provider from time to time). The Claims Service Provider must provide icare with all relevant information that icare requires to make an informed decision, including:

(i) the nature of the threat or danger that may arise;

(ii) evidence as to the potential threat or danger;

(iii) the information that may give rise to the threat or danger;

(iv) any possible measures by which the information may be de-identified, or otherwise remove the potential threat or danger;

(v) reasoning behind not releasing information to a medical practitioner nominated by the Worker or the Worker's legal representative;

(vi) whether the Worker is self-represented; and

(vii) any other information relevant or requested by icare.

8.2 Release of Information to Employers

(a) Subject to legal professional privilege, the Claims Service Provider may release information forming part of a Worker's Claims Record to an Employer on request where necessary to prevent a serious and imminent risk to the Worker or another person's safety or to facilitate the Employer's Injury Management and Return to Work obligations concerning the Worker.

(b) In all other circumstances, the Claims Service Provider should seek icare's instructions regarding the release of the information from icare via the Significant Legal Matters Mailbox (SLM@icare.nsw.gov.au or as otherwise notified by icare to the Claims Service Provider from time to time).

8.3 Requests for information from third party insurers

From time to time, third party insurers may request Claim documentation to assist in their assessment of Claims for other types of insurance and superannuation. icare Approves the release of this information subject to the following conditions:

(a) the request must be made in writing and include a consent form signed by the Worker that authorises the release of Workers Compensation information to the third party;

(b) the Claims Service Provider must be satisfied that, in signing the form, the Worker has consented to the release of Personal Information to the third party; and

(c) the information requested must be provided in a secure and confidential manner to the third party insurer.

9. Fraud Management

9.1 Overview

(a) The Claims Service Provider must develop and comply with a Fraud Risk Management Model that includes strategies for the prevention, identification and investigation of Fraud and Suspect Activity. The Fraud Risk Management Model must document a proactive approach to routinely assessing Fraud risk, identifying and documenting controls, executing monitoring and testing controls that are aimed at minimising the impact of Fraud and Suspect Activity on the Workers Compensation Scheme Principles.

(b) The Claims Service Provider must implement SIRA and icare recommendations where those recommendations are reasonably necessary to strengthen the Claims Service Provider's Fraud risk management arrangements.

(c) The Claims Service Provider must have a Fraud Risk Management Model in place before it provides any Claims Management Services under the Contract.

9.2 Scope

The Claims Service Provider's Fraud Risk Management Model must:

(a) include mechanisms that identify and assess Fraud risk, and clearly document the processes and controls in place to prevent Suspect Activity and Fraud on the Scheme by the Claims Service Provider, its Related Bodies Corporate, Third Party Service Providers, Key Input Providers, Workers and Employers;

(b) be designed to enable the Claims Service Provider to achieve all Performance Measures in each Reporting Period;

(c) comply with all legislative requirements and be in line with Australian Standard AS 8001:2021 *Fraud and Corruption Control Standards* (including subsequent standards); and

(d) contain:

(i) formal reporting of Suspect Activity and Fraud including to the Portfolio and Performance Meeting or sub-committee, or Strategic Leadership Meeting, as appropriate;

(ii) detailed procedures for the management of all aspects of Suspect Activity and Fraud;

(iii) training modules and educational materials for Personnel in relation to Suspect Activity and Fraud and the procedures for its management and internal reporting. This must include any necessary tools such as a checklist and fact sheets for easy reference and everyday use;

(iv) requirements for the engagement of external investigators, including service level agreements and performance criteria; and

(v) all documentation and templates necessary to ensure that all reports, statements, evidence and records of Suspect Activity and Fraud meet the requirements in this Contract and at Law.

9.3 Reporting and Timeframe Requirements

(a) The Claims Service Provider must manage all instances of payment Fraud, including cheque and electronic funds transfer, in accordance with the requirements detailed in Attachment 5.01 (Banking Manual).

(b) The Claims Service Provider must report all internal and external Suspect Activity and Fraud to icare in writing promptly and at least within five Business Days of the Claims Service Provider becoming aware of the Suspect Activity and Fraud. As part of that report, the Claims Service Provider must inform icare what date the Claims Service Provider discovered the Suspect Activity or Fraud.

(c) (***Internal Suspect Activity or Fraud***) Unless otherwise agreed by the parties in writing, the Claims Service Provider must undertake the following actions and comply with the following timeframes in the management of any internal Suspect Activity or Fraud:

(i) describe its current and proposed management of the Suspect Activity or Fraud to icare within two Business Days of the Claims Service Provider reports the Suspect Activity or Fraud to icare;

(ii) complete desktop reviews and provide reports to icare within ten Business Days from the date the Claims Service Provider becomes aware of the Suspect Activity or Fraud to icare;

(iii) complete case manager statements within 10 Business Days of icare requesting the statement;

(iv) cooperate with icare and assist with all analytical activity required to support any investigation into the Suspect Activity or Fraud;

(v) support icare with conducting root cause analysis, controls review and control hardening actions as required and within timeframes agreed with icare's internal investigations team; and

(vi) keep icare informed of all findings and developments regarding the Suspect Activity or Fraud.

(d) (***External Suspect Activity or Fraud***) Unless otherwise agreed by the parties in writing, the Claims Service Provider must undertake the following actions and comply with the following timeframes in the management of any external Suspect Activity or Fraud:

(i) complete desktop reviews and provide reports to icare within 10 Business Days from the date the Claims Service Provider becomes aware of the Suspect Activity or Fraud;

(ii) all clinical notes to be requested within five Business Days from the date the Claims Service Provider becomes aware of the Suspect Activity or Fraud, and take reasonable steps to ensure all clinical notes are obtained within ten Business Days from the date of that request;

(iii) undertake data and information analysis as required by icare, including to to support the investigation, and provide all findings to icare on completion;

(iv) in the event that physical surveillance is required, the Claims Service Provider must request Approval from icare at least five Business Days prior to instructing any Third Party Service Provider;

(v) physical surveillance instructions to Third Party Service Providers must be issued within two Business Days of Approval being received from icare, and must incorporate requirements and timeframes as instructed by icare;

(vi) physical surveillance reports must be provided to icare within two Business Days of receipt of the report;

(vii) all case manager statements must be completed within ten Business Days of icare requesting the statement;

(viii) unless otherwise agreed by the parties in writing, provide icare with its final investigation outcome within three months from the date the Claims Service Provider becomes aware of the Suspect Activity and Fraud and complete the relevant sections of icare's "Suspect Activity and Fraud Incident Outcome Checklist", as provided by icare to the Claims Service Provider from time to time;

(ix) provide icare with progress reports of all open Suspect Activity and Fraud investigations every month, by the fifth Business Day of the subsequent month in the form set out in the relevant sections of the "Suspect Activity and Fraud Incident Outcome Checklist";

(e) icare may review any of the Claims Service Provider's Suspect Activity and Fraud process and procedures, including final closure decisions, and advise the Claims Service Provider of any remedial action required.

9.4 Competency of Claims Service Provider Personnel

The Claims Service Provider must:

(a) appoint a Fraud risk management leader with experience in managing, directing and overseeing Fraud prevention, analytical and investigation services in the financial services sector;

(b) appoint dedicated Fraud resources that collectively understand Claims Management Services, Banking and Financial Management Services, IT security and any Third Party Service Providers' operations and issues;

(c) ensure that the resources it appoints to Fraud prevention and investigation roles have the necessary knowledge, experience and skillset to:

(i) work with, and support, operational, finance and other Claims Service Provider Personnel with the identification, escalation and investigation of any Suspect Activity or Fraud in order to avoid Fraud that impacts the Scheme;

(ii) assess and analyse information across all business areas of the Claims Service Provider to develop hypotheses and make recommendations in regard to preventative and investigative action required to avoid Fraud that impacts the Scheme;

(iii) adequately understand all elements of Claims costs and other financial exposure for the Claims Service Provider and icare, and the basis of calculating estimated loss as a result of allegations of Fraud;

(iv) understand the relevance of finance records, including cheque and electronic funds transfer records, as evidence for a fraud investigation;

(v) understand how to trace Fraud when conducting an investigation;

(vi) collate, research, produce and analyse information and data from internal and external sources to assist in investigations and Fraud prosecution;

(vii) prepare high quality reports on Fraud risk management oversight activities, and credible, intelligence-based referrals to icare;

(d) notify icare of the number of its dedicated Fraud resources, along with their names, contact details and relevant skills and experience; and

(e) ensure that all its Personnel involved in Claims Management Services and Banking and Financial Management Services undertake Fraud identification and reporting training within 12 months of the Commencement Date or the date of the Personnel's appointment or engagement.

9.5 Authority of Claims Service Provider Personnel

The Claims Service Provider must ensure that its dedicated Fraud resources have sufficient authority within the Claims Service Provider's organisation to carry out enquiries and investigations into Suspect Activity and Fraud, including:

(a) having access to key stakeholders to facilitate research, investigations and prosecutions into Fraud and other potentially criminal activity that may have, or is, impacting the Scheme;

(b) to direct the Claims Service Provider's Personnel to produce documents, participate in interviews and respond to enquiries withing required timeframes;

(c) having unfettered access to all records of the Claims Service Provider;

(d) having access to necessary support from subject matter experts where needed to extract, or procure the extraction of, evidence (including from finance records) held by the Claims Service Provider.

10. Complaints

10.1 Complaints Management

(a) Compliance

The Claims Service Provider must adopt and comply with:

(i) the requirements of icare's Complaints Policy, Complaints Guidelines, the Complex Customer Circumstances Guidelines, the NSW Ombudsman's Guidelines for Managing Unreasonable Conduct by a Complainant and any other guidelines notified by icare from time to time;

(ii) icare's Complaint Levels categorisation;

(iii) the requirements of Australian Standards AS/NZS 10002:2022, AS/NZS 10002:2014 (including any revisions or replacements to those standards);

(iv) any Applicable Standards that may be implemented by icare throughout the Term; and

(v) regulatory and relevant State Privacy Laws requirements when managing a Complaint.

(b) Staff and Resourcing

The Claims Service Provider must ensure:

(i) all staff understand their roles and responsibilities in relation to Complaints;

(ii) it has sufficient resources to address Complaints with integrity and in an equitable, objective and unbiased manner; and

(iii) all staff managing Complaints have the authority, knowledge skills, training and tools to effectively perform their roles.

(c) Managing a Complaint

The Claims Service Provider must ensure:

(i) all complainants are provided with sufficient information about their escalation options should they be dissatisfied with the Claims Service Provider's response to a Standard Complaint;

(ii) Standard Complaints are resolved at first contact or where this is not possible, within five Business Days;

(iii) Standard Complaints that are determined to be Complex Complaints or that are unable to be resolved within the timeframes set out in the Knowledge Articles are escalated to icare to manage as a Complex Complaint within the set timeframes;

(iv) all Complaints and Complaint management activities are recorded in the Claims Technology Platform;

(v) sufficient information is captured in Claims Technology Platform to assist in identifying the root cause of the Complaint;

(vi) it analyses and acts upon the information captured on Complaints to implement improvements on the performance or quality of Complaints management or appropriate solutions to remediate, reduce or eliminate significant and recurring themes and problems;

(vii) it closes all Complaints records in the Claims Technology Platform within the timeframes set out in the Knowledge Articles;

(viii) subject to section 10.3 of this Schedule, information that is created by the Claims Service Provider, published and made available to customers about Complaints and the Complaints process, including on websites and written communications, is consistent with the Complaints Policy and any applicable Complaints Guidelines, Complex Customer Circumstances Guidelines and Applicable Standards. This section 10.1(c)(viii) does not apply to communications prescribed and created by icare; and

(ix) issue any correspondence to icare in relation to customer Complaints via email to the Claims Service Provider account mailbox.

10.2 Escalation

(a) Complaint Levels

(i) icare has adopted Complaint Levels to enable consistent and coordinated Complaints management and escalation. All Complaints received must be recorded and managed in accordance with the Complaint Level requirements as set out in the Complaints Guidelines.

(ii) Where the nature or subject matter of a Complaint involves more than one Complaint Level category or are raised concurrently (for example, Standard Complaints and External Complaints or Standard Complaints, Complex Complaints and Ministerial

Complaints), icare will be responsible for coordinating an appropriate single response to the Complaint.

(iii) Where a Complex Complaint, External Complaint or Ministerial Complaint is raised with icare, the Claims Service Provider must comply with any request or instruction issued by icare to:

(A) provide information about a particular claim or claims, or to provide copies of, or access to, material relating to the subject matter of the Complaint that is not accessible on the Claims Technology Platform;

(B) where appropriate, undertake a comprehensive review of the particular claim or claims to assist icare in providing a response to all matters raised involving Claims Service Provider Personnel; and

(C) where appropriate, remediate, reduce or eliminate any Significant issues identified.

(b) Escalation of Complaints to Performance Management Processes

(i) The Claims Service Provider must comply with:

(A) any instruction that icare may give to the Claims Service Provider to take a specified action on a Claim in relation to a Complaint; and

(B) a Remediation Plan Direction that icare may issue in relation to a Complaint, as if it were issued under clause 53.2 of the Contract Terms,

if:

(C) a Complaint has been lodged, or escalated, due to the actions or inactions of the Claims Service Provider to effectively resolve the Complaint;

(D) icare considers that the Claims Service Provider has had fair opportunity to resolve the Complaint but has not resolved the Complaint; and

(E) icare considers that the Claims Service Provider's action or inaction has had an adverse outcome on the complainant.

(ii) If icare's monitoring and oversight of Complaints handling by the Claims Service Provider identifies a Significant issue, icare may proceed with performance management processes or other remediation actions in accordance with this Schedule.

(iii) icare may advise SIRA of any Complaints that indicate that the Claims Service Provider has failed to inform icare when legislative requirements have not been met.

10.3 Publication

(a) If the Claims Service Provider wishes, or is required, to publish any information in relation to Complaints (including written communication, website, brochures, guides or information sheets), then unless otherwise required by Law:

(i) the Claims Service Provider must obtain icare's written Approval prior to publication;

(ii) in its published information, the Claims Service Provider must:

(A) ensure that Workers are made aware of the IRO, which provides an independent Complaint resolution service for Workers who are unhappy with a decision made by the Claims Service Provider; and

(B) provide contact information for IRO on the Claims Service Provider's website, including the contact number and website address.

(iii) in its published information, the Claims Service Provider must:

(A) ensure that Workers and Employers are made aware of SIRA, which provides an independent Complaints resolution service for Employers and service providers; and

(B) provide contact information for SIRA on the Claims Service Provider's website, including the contact number and website address.

(b) Some Complaints may be resolved by referral to a dispute pathway, such as the PIC. The Claims Service Provider must provide contact information for the PIC on the Claims Service Provider's website, including the contact number and website address.

11. Attachments

Attachment 1.01 (*Claims RACI*)

Attachment 1.02 (*Claims Estimation Manual*)

Attachment 1.03 (*Treatment Decision Making Framework*)

Attachment 1.04 (*Professional Standards Framework*)

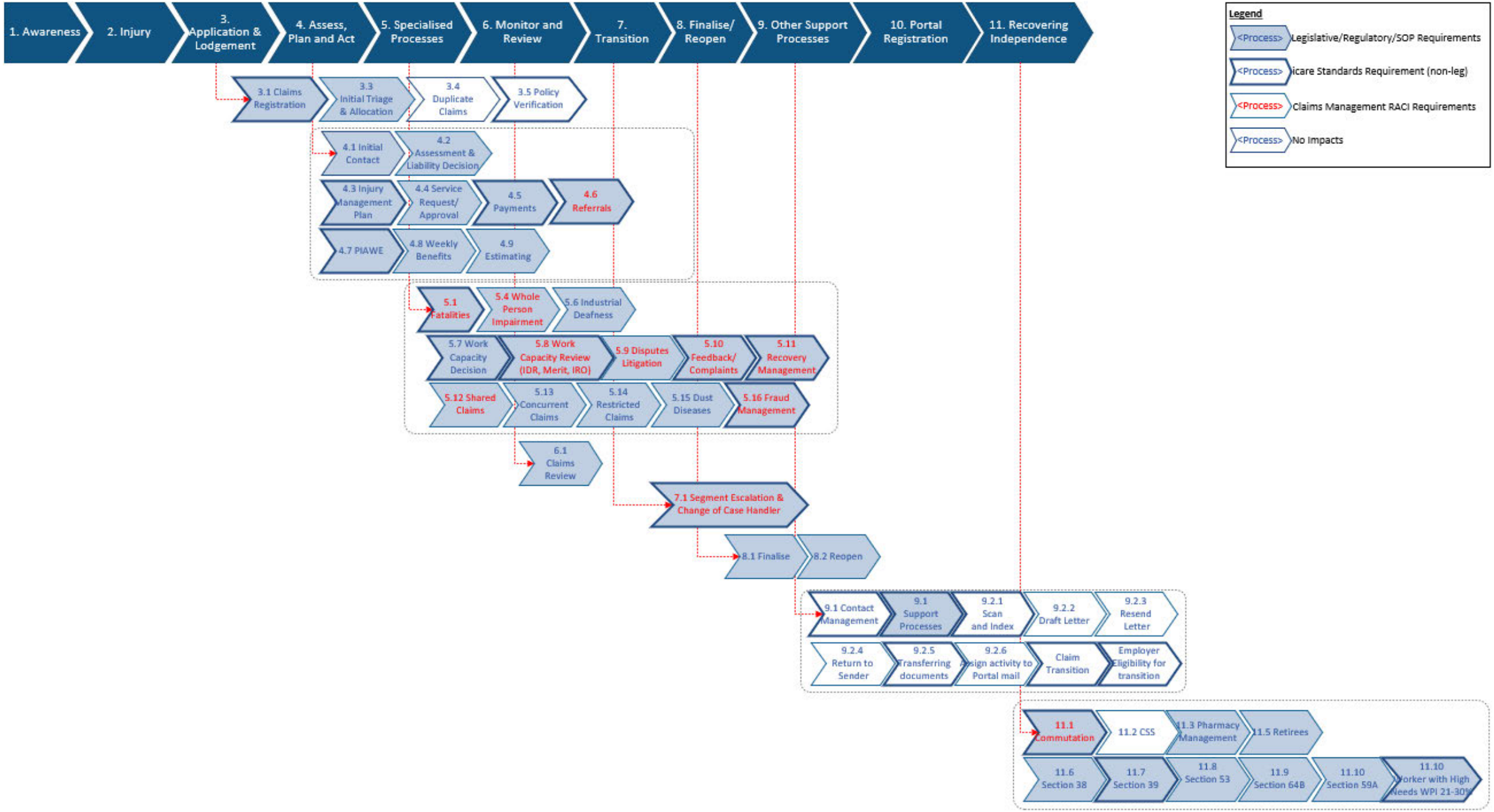
Claims Management RACI

Decision	Agent	icare
1. LIABILITY		
Determine liability (fatalities)	A, R	I
Determine liability (significant claim event)	A, R	C
2. TREATMENT		
Approval of new & novel treatment, partial approval or declinatures (all services without an AMA or SIRA payment code & medicinal cannabis)	A, R	C
3. REFERRAL FOR SERVICES		
Approve covert optical surveillance	R, C	A
Approve high value items / service >$150K	R	A
Home modifications >$70K	R	A
4. WHOLE PERSON IMPAIRMENT (WPI)		
Determine whether Worker meets definition of "Worker with Highest Needs" per section 32A (where WPI has not been assessed and agreed as >30%)	A,R	C
5. SERVICE SEGMENT ESCALATIONS		
Escalation to Workers Care OR Lifetime Care (as per agreed procedure in WIAF)	C	A
6. COMMUTATION / LONG TAIL MANAGEMENT		
Negotiate and approve Commutation amount	A	I
7. COMPLEX BEHAVIOUR		
Manage serious threats of self-harm or harm to others	A	I
8. COMPLAINTS		
Respond, resolve and close Standard Complaints within set timeframes	A	I
Escalate Complex Complaints to icare to manage within set timeframes	A	I
Respond, resolve and close Complex Complaints within set timeframes	C (where reasonably practicable)	A

Claims Management RACI

Decision	Agent	icare
9. INTERNAL REVIEWS AND DISPUTES		
Review a challenged Work Capacity Decision	A	I
Review a challenged liability decision	I	A
Approve legal referral associated with an internal review (dispute)	I	A
10. SIGNIFICANT LEGAL MATTERS		
Identify and report significant legal matters and potential Significant legal matters to the Principal	A	I
Strategy of Significant legal matters	I	A
11. GENERAL		
Cease recovery action where potential has been clearly identified	A	I
Raise and review suspected fraud	A	I
Refer suspected fraud to SIRA	I	A
Determine party at risk for shared claims	A	I (escalation if disagreement between Agents)

Proposed Processes impacted by Legislation, Non-Leg icare Standards and Claims Management RACI



icare
Insurance and Care NSW

Claims estimation manual

October 2022

icare™
Insurance and Care NSW

Contents

Purpose

This Manual outlines icare's requirements regarding the estimation of claims. It applies to all open, reopened and new workers compensation claims that are subject to the Workers Compensation Act 1987 ("1987 Act") and Workplace Injury Management and Workers Compensation Act 1998 ("1998 Act").

This Manual is also used to calculate estimates for claims administered under the Loss Prevention and Recovery (LPR) scheme. Estimates are critical in assessing the LPR model and are used to set future premium rates. Updating estimates at the nominated review points informs an accurate premium forecast. In addition, accurate estimation at the 48-month adjustment enables correct 'ultimate' premium to be charged and avoids putting strain on the premium adjustment factors.

Claims Service Providers must:

- estimate the claim in accordance with this Manual;
- ensure the estimates reflects the legislative provisions that apply to the claim at the review point; and
- review estimates at each review of the claim (either scheduled or event driven) to ensure the estimate is up to date.

This Manual is not a claims administration or injury management manual – for requirements and guidelines regarding claims management and administration refer to:

- SIRA Workers Compensation Guidelines;
- SIRA Workers Compensation Benefits Guide;
- SIRA Standards of Practice;
- SIRA Claims Management Guide
- Workers Compensation Insurer Data Reporting Requirements;
- Various gazetted Fees Orders; and
- Workers Compensation Regulation 2016 (NSW).

Commencement

This Manual applies to every new estimate and every review of an estimate for all claims.

The general principles and approach outlined in Chapters A to G apply to all claims.

Claims Service Providers must base their estimates on the timeframes contained in Chapters H to P and Table Five.

Claims Service Providers must have regard to Chapter I when calculating estimates for death claims.

Note: When applying estimates for exempt workers, Claims Service Providers must have regard to these exemptions and must also refer to the legislation that was in force prior to the commencement of the 2012 amendments to ensure benefits and entitlements are correctly estimated and paid.

Using this Manual

The Manual sets out:

1. the approach and process that must be followed for every claim estimated - refer to Part One; and
2. detailed requirements for each type of claim - refer to Part Two.

Amounts used in this Manual are subject to change and will be reviewed as required in accordance with changes in legislation, gazettes or Guidelines. The Manual will be updated by icare in accordance with the changes.

Pending any revision of the Manual, Claims Service Providers may use different amounts if legislation, gazettes, and Guidelines require them to do so.

All amounts in this Manual are inclusive of GST.

Review of the Manual

The Manual is subject to review and updates will be published as required.

Monitoring estimates

SIRA or icare may monitor estimates through audit results, statistical analysis and claim reviews.

Glossary

Term	Meaning
1987 Act	Workers Compensation Act 1987 (NSW)
1998 Act	Workplace Injury Management and Workers Compensation Act 1998 (NSW)
ARD	Application to Resolve a Dispute
AWE	Average Weekly Earnings
CSP	Claim Service Provider
CTP	Compulsory Third Party scheme
GST	Goods and Services Tax
Guidelines	SIRA Guidelines
LPR	Loss Prevention and Recovery scheme
MAC	Medical Assessment Certificate
Manual	This Claims Estimation Manual, as amended from time to time
PIAWE	Pre-Injury Average Weekly Earnings
PIC	Personal Injury Commission
SIRA	State Insurance Regulatory Authority
Workers With Highest Needs	Workers with an assessed degree of permanent impairment greater than 30%
Workers With High Needs	Workers with an assessed degree of permanent impairment greater than 20% but not more than 30%
WPI	Whole Person Impairment

PART One: Approach and process

Chapter A: Estimating Approach

1. The Claims Service Provider must:

   1.1 keep claim estimates up to date, even in between scheduled and event driven review points;

   1.2 build claims estimation into the organisation's routine case management and review processes;

   1.3 use the amounts specified in this Manual unless there is evidence otherwise, then use a soundly-based decision-making process to estimate claims;

   1.4 maintain accurate estimates on claims to ensure the premium is correctly calculated;

   1.5 ignore the possible effect of inflation when estimating and always use current amounts;

   1.6 exclude payments already made;

   1.7 exclude recovery or adjustments arising from input tax credit or decreasing adjustment mechanism; and

   1.8 maintain an appropriate estimate on the claim until it is finalised.

Chapter B: Estimating Process

Worker Entitlements

2. The worker and/or their dependants are entitled to the benefits set out under New South Wales legislation. The Claims Service Provider must ensure a soundly based decision-making process has been undertaken using all the available information in consideration of all the relevant benefits for every estimate, and for every review of an estimate. As more information becomes available, a worker's entitlements may change. The estimate must be kept up to date in relation to every potential benefit the worker may be entitled to receive.

Evidence Required to Support Review Estimate (the Worksheet)

2.1 The Claims Service Provider must keep detailed records of each review showing at least:

- the review has been completed;
- the factors making up the total estimate;
- any reasons why the estimate is not in accordance with this Manual; and
- the date on which the estimate or review was completed.

Requirements for computer records

2.2 If the details are recorded only on the Claims Service Provider IT system, the system must keep a historical record of all the estimates and reviews on the file including the date on which the estimate or review was prepared. These documents are required for any future applications for review of the premium by an employer under section 168 (1987 Act).

Chapter C: Calculating medical, hospital, rehabilitation (section 60) and other expenses

Considerations when calculating expenses for medical, hospital, rehabilitation etc

3. When calculating the estimate of future section 60 expenses (1987 Act) (medical, hospital, rehabilitation, etc.) the Claims Service Provider must take into account the nature and severity of the injury, as well as the need for and the anticipated costs of any medical treatment. The Claims Service Provider must ensure the treatment is reasonably necessary and evidence based.

Note: Claims Service Providers must ensure that medical, hospital, rehabilitation and other section 60 expenses are estimated and paid in accordance with legislative provisions.

Evidence of Costs

4. The Claims Service Provider must pro-actively gather relevant information to make an informed decision about the costs to estimate. Always review estimates when new information comes to hand. Information can include but not be limited to:
   - specialist reports;
   - injury management consultant and/or other investigation reports;
   - requests for approval for surgery and/or provision of services;
   - rehabilitation reports; and
   - certificate of capacity.

Treatment is complete

5. The Claims Service Provider must remove the estimate when the service or treatment is complete and paid, and it is anticipated that no further service or treatment is required.

   For example:
   - Once surgery has been performed and the post-operative specialist report has been reviewed to exclude further surgery or extended hospital admission, and confirmation has been received from the provider that all payments have been made, future expenses are not required unless there will be costs for removing fixative devices.
   - If the worker has returned to work with no further wage loss, any estimate for future weekly benefit payments and allowance for rehabilitation expenses need not be included.

Limits for medical expenses and property damage compensation

5.1 Sections 61, 62, 63, 63A(3), 76 and 77 of the 1987 Act outline the maximum limits prior to further approval for which an employer is liable to pay compensation. These limits are gazetted through the SIRA Benefits Guide, which is issued each April and October. Claims Service Providers must estimate in accordance with this Manual where the expected costs of the claim are not known. Any variance in the estimate applied should be appropriately file noted for justification.

Section	Description
61	Medical or related treatment
62	Hospital treatment
63	Ambulance service
63A	Occupational rehabilitation services
76	Damage to artificial limbs, spectacles
77	Damage to clothing

Chapter D: Recoveries

6. Claims Service Providers are able to recover costs incurred on a claim through the application of section 151z (1987 Act). Some common forms of recovery include:
    - compulsory third party;
    - industrial deafness;
    - public liability; and
    - shared claims.

    Recovery can be included in an estimate when the other party has admitted liability, or where the potential for recovery is:
    - clearly apparent;
    - sustainable at law;
    - soundly anticipated; and
    - verified by a suitably qualified person.

Recovery Amounts

7. The recovery estimate must be based on the information available on file. If Rule 6 pre-conditions have been met and there is insufficient evidence for quantum then estimate 50%.

    At subsequent review points, if there is no clear information regarding the likelihood of recovery, then reduce the recovery estimate to zero. If there is evidence that liability exists but the quantum is unknown, continue to use 50%. In consideration of reducing the estimate, review any police reports, factual investigation reports, etc or obtain legal advice before reducing the estimate to zero. Where these reports confirm clear liability exists, then continue to estimate for recovery.

    If up to date information is received, at any point, immediately update the estimate. This may result in a recovery greater than 50%.

Amounts to apply the recovery percentage to

8. Apply the recovery percentage to all parts of the estimate but not the:
    - investigation costs; and
    - legal costs.

    Claims Service Providers should familiarise themselves with the provisions and limitations pursuant to CTP legislation e.g. assessment of lump sum entitlements and calculate the estimate accordingly.

Chapter E: Disputed and litigated claims

9. Claims must be estimated in accordance with this Manual even when the claim is disputed, litigated or 'reasonably excused' (refer to the SIRA Claims Management Guide for information on potential grounds for dispute), excluding notification only claims. Schedules 6 and 7 of the Workers Compensation Regulation 2016 (NSW) (as varied from time to time) must be used when estimating for legal costs.

Calculating an estimate for a disputed claim

9.1 For a disputed claim, the estimate is calculated the same way as for a claim that is not in dispute. Include all amounts claimed even if they may not be paid and include an estimate for legal costs. Use Part Two of this Manual to calculate the estimate. This includes those notifications where a reasonable excuse has been applied (for not commencing provisional payments of weekly compensation, excluding notification only claims).

Removing or reducing estimates on litigated/disputed claims, work capacity decisions or s66 entitlements

9.2 If a reasonable excuse exists or if a dispute, payment discontinuance notice or work capacity decision has been issued to the worker, maintain the estimate for at least three months after the date that notice was issued to the worker. If the worker and/or their representative have not responded within three months, then consider whether to reduce the estimate or finalise the claim.

If a claim has been disputed and a Claims Service Provider receives a request for a review under s287A of the 1998 Act and/or a request for information from the worker and/or their representative in order for them to advise the worker on their entitlements, the claim must remain open for a further three months after either the date of the review or the supply of the requested information.

The claim must remain open with an estimate for any outstanding reimbursement schedules or accounts for investigation expenses requested by the Claims Service Provider. The claim may be finalised once these payments have been made and a sound decision process regarding finalisation has taken place.

If a Claims Service Provider declines to pay a benefit under section 66 (1987 Act) because the permanent impairment assessment relied upon by the Claims Service Provider does not meet the necessary legislative thresholds and a dispute notice is issued, the estimate that was in place prior to the dispute is to be maintained for a period of three months or until the dispute is finalised.

If a Claims Service Provider makes an offer to pay a benefit under section 66 (1987 Act) for an amount less than that outlined in the worker's claim, the estimate that was in place prior to the dispute is to be maintained until the dispute is finalised.

Estimated legal amounts for litigated/disputed claims

9.3 Claims Service Providers are to estimate for legal costs in a staged and sequential manner.

General resolution types

9.4 Initial estimates for legal costs for a disputed matter that falls within "General resolution types", must as a minimum reflect the item cost associated with resolution of the issue/s in dispute using the criteria as detailed in Schedule 6 of the Workers Compensation Regulation 2016 (NSW).

If the matter does not resolve in accordance with the anticipated outcome, the estimate must be increased to reflect the next stage of dispute resolution. Estimates must also include allowances for regulated disbursements as appropriate.

Note: Legal costs must be estimated in accordance with legislative provisions in force at the time.

Estimates for all other matters

9.5 Estimates for legal costs in all other matters must have regard to the issue/s in dispute and use the corresponding Item/s from the relevant Table/s.

Matter does not resolve at PIC due to ARD being withdrawn.

9.6 Where an ARD has been issued but the dispute is not initially resolved at the PIC on the basis that the matter is withdrawn because the worker's claim is not ready to proceed for whatever reason; this is not to be regarded as resolution of the matter.

At this point, the estimate should if necessary, be adjusted to reflect the issue/s in dispute, pending the future resolution of the matter by the PIC. This estimate must be maintained for a further minimum period of three months (or longer as appropriate having regard to the individual circumstances of the claim and the reasons why the claim did not proceed), pending referral back to the PIC.

Chapter F: Timing of Estimates

10. The Claims Service Provider must complete the following in respect of any new claim and existing claim for which recovery is being pursued:
    - an estimate on receipt of an initial notification or a claim - refer to Rule 11;
    - regular ongoing estimates - refer to Rule 12; and
    - an updated estimate upon receipt of relevant new information or documentation (e.g. request for medical procedure or change in circumstances such as a change in work capacity certification) - refer to Rule 12.

    This also applies to claims for which recovery is being pursued.

Initial Estimates

11. The Claims Service Provider must complete an initial estimate of the claim and record the estimate on the claims management system within one week of receiving the claim or an initial notification. This includes those claims where a reasonable excuse has been applied for not commencing provisional payments of weekly payments.

Ongoing review of estimates

12. The Claims Service Provider must review estimates:
    - within 14 calendar days either side of each of the review points shown in Rule 12.1;
    - in between these review points as new information comes to hand; and
    - prior to policy renewal date to ensure accuracy of premium calculation.

    Note: Where the policy renewal date falls within this 28 day period, the review is to be conducted no later than the policy renewal date, and is to be based on the review point that would apply at renewal.

    12.1 As a minimum, the Claim Service Provider must review each open claim:

    - 12 weeks after the date of notification;
    - 26 weeks after the date of notification;
    - 52 weeks after the date of notification;
    - 78 weeks after the date of notification;
    - 104 weeks after the date of notification;
    - bi-annually after 104 weeks after the date of notification; and
    - for LPR policy holders, 2 months prior to the 48-month adjustment.

Other factors to consider when completing ongoing estimates

12.2 The Claims Service Provider must consider these factors when completing the estimate:

- factual, surveillance or medical investigations. If any are likely, allow as a minimum $2,000 but review as new evidence becomes available;
- recovery action - refer to Chapter D;
- Permanent Impairment – refer to Chapter N Permanent Impairment (section 66 of the 1987 Act) Entitlements for claims made on or after 19 June 2012;
- wage re-imbursement schedules - refer to Rule 15;
- expected legal expenses - refer to Chapter E; and
- confirm the worker's current work capacity and ensure the weekly benefit rate reflects the correct entitlements and (if appropriate) the most recent indexation. Adjust as required and use the new amount to calculate the estimate.

Annual independent peer reviews on claims attached to an LPR customer

13. Each year, an independent person is to comprehensively review the estimate for every open claim. The independent person is to be a suitably experienced, expert independent case manager or a senior staff member who is not responsible for the daily management of the file. The independent review is to be conducted during a scheduled review each year.

Chapter G: General Estimate Practices

Insufficient evidence to adjust the estimate

14. The Claims Service Provider must not change the estimate based on the following:
    - unsupported information from any source (including the employer or a rehabilitation provider) that the worker has, or will, return to work on full duties;
    - a medical report indicating a future return to work which is not supported by a change in work capacity certification;
    - surveillance reports;
    - an allegation of fraud;
    - the worker returning to work without the support of the treating doctor:

Wage Reimbursement Agreements

15. Claims must be estimated in accordance with this Manual. Claims Service Providers must not reduce or change an estimate without supporting evidence that substantiates a worker's capacity for work i.e. whether there is an entitlement to weekly payments or not except where provided below.

    Where a wage reimbursement schedule agreement is in place between the Claims Service Provider and an employer, the employer must:

    a. Submit a wage reimbursement schedule within one calendar month of the payment of the weekly compensation payments to a worker,

    b. Forward to the Claims Service Provider any documentation in respect to a claim for weekly compensation i.e. a certificate of capacity, within seven days of receipt.

    For LPR policies, at any review point where:

    - the employer has not provided the Claims Service Provider with the reimbursement schedules for three consecutive months, or
    - if the employer has not been compliant with the requirements specified in Section 69 of the 1998 Act when requested to provide specified information to the Claims Service Provider in the form of the outstanding wage reimbursement schedules, the claim must be estimated as if the worker's last known certified incapacity was "no current work capacity".

    When premium renewal is due and the employer has either not provided applicable wage reimbursement schedules or has sent in wage reimbursement schedules for periods in excess of one month worth of reimbursement within one month of policy renewal, then the estimate shall remain at the rate calculated through the renewal period and will only be reduced once the employer has maintained consistent provision of reimbursement schedules for a period of three months.

    The estimate in place at the policy renewal date will be used for the purpose of calculating the cost of individual claims for the purpose of premium calculation in accordance with Rule 145 (1) (e) of the Workers Compensation Regulation 2016 (NSW).

Estimating Requirements - Weekly Benefits and medical expenses – Retiring Age

16. In calculating estimates for weekly payments, if a worker is entitled to ongoing weekly benefits, then:

- if the injury occurred before the retiring age, weekly benefits are paid until the worker has reached the first anniversary after retiring age; or
- if the injury occurred after the retiring age, weekly benefits are paid for a maximum of 12 months after the first date of weekly benefits for the incapacity for work.

Any estimate should take this into account. If there is no clear evidence about expected period of incapacity, use the period shown in Table Five for the worker's type of injury.

Refer to section 59A of the 1987 Act for time limits on entitlements to medical expenses (not applicable to exempt workers).

Claims Service Providers must have regard to transitional provisions that apply to claims made prior to 1 October 2012 in determining a worker's entitlement to medical expenses.

Worker's employment is terminated/made redundant on claims attached to LPR customers

17. If a worker who has an entitlement to weekly payments has their employment terminated or is made redundant (including a worker who was working suitable duties/employment with no "make up" pay), the Claims Service Provider must immediately increase the estimate as shown in the following table, plus include an allowance for any unpaid or outstanding weekly benefit amounts. The table is also to be used at subsequent estimate review points until the worker recommences employment.

Note: If the estimate calculated by rules elsewhere in this Manual is greater than the estimate required by the following table – use that estimate. Claims Service Providers who manage claims for exempt workers who are terminated/made redundant are able to use amounts greater than that specified in the following table.

If the worker's employment was terminated and/or the worker was made redundant and the worker has an entitlement to weekly payments and the review date is …	**Estimate required**
less than 26 weeks after the date of the injury	Increase the estimate to allow the lesser of 104 weeks of weekly payments or to the first anniversary after retiring age.
more than 26 weeks after the date of the injury	Claims Service Providers must have regard to the date claim made, work capacity status of the worker and the level of permanent impairment. Increase the estimate to allow the lesser of a period up to 130 weeks of weekly payments inclusive of payments paid or to be paid; or to the first anniversary after retiring age. However, if a worker has an entitlement to weekly payments beyond 130 weeks, increase the estimate to allow the lesser of a period up to 260 weeks of weekly payments inclusive of payments paid or to be paid; or to the first anniversary after retiring age.

Worker Recommences Employment

17.1 If the worker recommences employment after termination/redundancy adjust the estimate having regard to the certificate of capacity, the circumstances of the claim and the relevant

Chapter in this Manual.

Example: A worker is diagnosed with a Table Five injury that requires an estimate for eight weeks of weekly payments. The worker is terminated three weeks post date of injury. The estimate would immediately increase from an incurred cost of eight weeks of weekly payments to the lesser of:

a) an incurred cost of 104 weeks of weekly payments; or

b) the appropriate amount from the date of last payment of weekly compensation to the first anniversary after the worker's retiring age.

This estimate would be maintained at the 12 week review and subsequent reviews that may arise from any change in work capacity. The estimate would next be reviewed at either the 26 week review point or when the worker returns to employment.

PART Two: Requirements for each type of claim

Chapter H: Work Capacity

Claims Service Providers must have regard to the special exemptions that apply to certain workers e.g. police officers, paramedics, fire fighters and coal miners. Claims Service Providers must also have regard to these exemptions as well as other legislative amendments that came into effect on 19 June 2012. The following tables assist in determining which of these categories the worker is in and refers to the Chapters in this Manual.

18. For claims made on or after 1 October 2012 and/or as a result of legislative amendments which have been commenced after 19 June 2012.

Worker's Capacity	Incapacity status	Refer to
Evidence demonstrating the worker has no current work capacity; but the permanent impairment has either been assessed at or is anticipated to be less than 31%.	No current work capacity	Chapter J
Worker has been assessed at or is anticipated to have permanent impairment greater than 30% regardless of the work capacity status of the worker	Worker's with Highest Needs	Chapter K
Workers working for the same employer, or a different employer who meet at least one of the following criteria: • who have current work capacity as a result of an injury and have an ongoing wage loss; or • who have had a "work capacity decision" made in respect of their ability to work.	Work capacity – at work	Chapter L
Workers who have a work capacity but whose employers are unable to provide them with suitable duties.	Work capacity – not at work	Chapter M
If the worker's injury has resulted in a permanent impairment.	Permanent impairment Section 66 of the 1987 Act	Chapter N
If the worker sustained a hearing loss	Permanent impairment Section 66 of the 1987 Act	Chapter O
If the worker is deceased	Part 3 Division 1 of the 1987 Act	Chapter I

Chapter I: Death Benefits

Benefits payable

19. The benefits that are payable when a worker dies as a result of a workplace injury include:

- a lump sum;
- weekly payments for dependent children (if applicable); and
- funeral expenses (including transportation of the deceased).

The lump sum benefit payable is the amount that is applicable at the date of the worker's death. With the exception of funeral expenses, all death benefits including weekly payments for dependants are indexed in April and October each year. The benefit payable for funeral expenses is specified by section 26 of the 1987 Act.

Claims Service Providers must ensure that the estimate for death benefits is calculated having regard to the individual circumstances of each claim including the number and age of dependants. Please refer to the 1987 Act and SIRA Benefits Guide for further information.

Chapter J: No Current Work Capacity

20. This Chapter applies to Workers where there is evidence demonstrating the worker has no current work capacity; but the permanent impairment has either been assessed at or is anticipated to be less than 31% Whole Person Impairment (WPI).

    You may also use this section to estimate costs where there is evidence on file to indicate that the worker will only have no current work capacity for a short period, such as an aggravation or removal of internal fixatives following surgery. Estimate should be based on the facts of each case.

    In situations where a worker sustains an injury (e.g. hernia) but does not initially require time off work but at a later date undergoes surgery and has no current work capacity; estimate the claim in accordance with Table Five or such other available information.

    If at any point the worker is assessed as having “no current work capacity” which is likely to continue indefinitely and a permanent impairment greater than 30% WPI refer to Chapter K – Workers with Highest Needs.

Estimating for weekly compensation payments

21. When estimating, the Claims Service Provider must always consider the worker’s capacity for work at the time of the review. Employers and workers will need to provide information about the pre-injury average weekly earnings (PIAWE) to a Claims Service Provider. The level of entitlement for weekly payments may vary depending on the amount of benefits already paid. Include in the estimate the total amount of weekly payments for the number of weeks the worker is expected to be off work. Refer to Table One - No Current Work Capacity.

    The level of permanent impairment is one of the drivers for estimating the duration of entitlements for weekly payments. Claims Service Providers must monitor any Whole Person Impairment assessment to ensure the correct estimate is applied.

Change in Work Capacity

22. If there is a change in the worker’s work capacity, then refer as appropriate to either Chapter L – Work Capacity – At work or Chapter M - Work Capacity – Not at Work.

Worker or employer does not claim weekly payments

23. If the worker is entitled to weekly payments, the Claims Service Provider must include the amount in the estimate regardless of whether or not the employer is claiming those benefits. The Claims Service Provider must maintain an estimate until the claim is finalised.

Current estimate likely to be inadequate at any point

24. If an estimate is inadequate at any point, the Claims Service Provider must review the claim and re-estimate as appropriate. Firstly, ensure the most recent estimate was calculated correctly in accordance with this Manual for the appropriate review point. If the estimate is still likely to be inadequate, then base the new estimate on the information available. If no information is available or the estimate is still insufficient the Claims Service Provider should then proceed to the next review point in advance.

Reducing an estimate

25. The Claims Service Provider can reduce an estimate for weekly payments for a claim when the worker returns to work with no ongoing wage loss.

    The Claims Service Provider must review the estimate considering:

- any future incapacity (e.g. future surgery, time loss for ongoing treatment, removal of internal fixatives, etc.);
- medical or rehabilitation costs;
- possible permanent impairment entitlements;
- ensure the estimate is sufficient to pay any outstanding wage reimbursement schedules;
- whether allowances for investigation costs and other expenses are required. If so, allow as a minimum $2,000 and review the estimate as more information is received;
- future costs of other compensation payments such as: aids and equipment; property damage; travel and accommodation; home care services; interpreter costs; etc.

The Claim Service Provider must update the estimate upon receipt of additional information and review the estimate at the next review point.

Worker requires time off work after returning to work on claims attached to LPR customers

26. If the worker requires time off work after returning to work, the Claims Service Provider must estimate in accordance with the following table:

Expected period of incapacity on available evidence …	**Weekly Benefits, Medical, Hospital, Other ...**
Less than four weeks	Estimate on the scenario most likely to arise for that claim. This may be a Table Five estimate.
Four weeks and more	Estimate using the next review point determined by the date of injury unless medical evidence indicates a Table Five estimate is more appropriate.

Worker has returned to work with no wage loss but requires ongoing medical treatment

27. Where a worker has returned to work without further expected wage loss but there is an indication that ongoing medical treatment is required, allow a minimum of $1,500 for medical treatment.

No allowance for hospital is generally required. If future hospital treatment is indicated, allow at least $5,000. If a referral has been made for rehabilitation, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional $2,000.

Update the estimate upon receipt of additional information and review the estimate at the next review point.

Refer to section 59A of the 1987 Act for time limits on entitlements to medical expenses (not applicable to exempt workers).

Table One: No Current Work Capacity

Benefits – No Current Work Capacity

<table>
<tr><th>Weekly</th><th colspan="8">Medical, Hospital, Rehabilitation expenses</th><th>Investigation and Other expenses</th></tr>
<tr><td rowspan="4">Include the total amount of weekly compensation payments for the number of weeks that the evidence suggests the worker will be off work or refer to Table Five.

Evidence to consider:
• discussions with the employer, worker, doctor and rehabilitation provider;
• the current certificate of capacity. Review dates and the expected period of incapacity;
• the anticipated duration of the injury and associated weekly benefit costs;</td><td colspan="8">The estimate for medical, hospital and rehabilitation expenses must reflect those expenses for reasonably necessary treatment.

Use the amounts shown in the following table unless there is evidence that another amount is more appropriate.</td><td rowspan="4">Investigation costs

If an independent medical or other investigation may be required, allow as a minimum $2,000 and review the estimate as more information is received.

Other expenses

Consider also estimating, as appropriate, future costs of other compensation payments such as: aids and equipment; property damage; travel and accommodation; home care services; interpreter costs; etc.</td></tr>
<tr><td rowspan="3"></td><td colspan="4">Non significant injuries < seven days incapacity</td><td colspan="4">Significant injuries ≥ seven days incapacity</td></tr>
<tr><td colspan="2">Level One</td><td colspan="2">Level Two</td><td>Level Three</td><td>Level Four</td><td>Level Five</td></tr>
<tr><td colspan="2">No actual time loss i.e. worker returns to work with no wage loss during period of incapacity e.g. worker injured but able to return to work before next rostered shift.</td><td colspan="2">Minor claim
Anticipated time loss
Less than seven calendar days</td><td>Injuries involving soft tissue, musculo-ligamentous, simple fractures etc. (excludes those requiring surgery).</td><td>Operative treatment</td><td>Worker with Highest Needs</td></tr>
<tr><td>• the anticipated duration and cost of any treatment plan (physiotherapy, chiropractic, osteopathy, psychology, etc.);</td><td>Medical & Treatment</td><td>No indication that ongoing treatment required</td><td>Indication that ongoing treatment required</td><td>No indication that ongoing treatment required</td><td>Indication that ongoing treatment required</td><td>$3,000</td><td>$5,000</td><td>Refer to Chapter K</td></tr>
<tr><td>• any medical reports provided by the treating doctor and any treating specialist</td><td>Hospital</td><td colspan="4">Usually nil but if the worker is or will be hospitalised allow at least $5,000 for hospital costs and review the estimate for medical and rehabilitation to reflect increased costs.</td><td>$5,000</td><td>Refer to Chapter K</td></tr>
<tr><td></td><td>Rehabilitation</td><td colspan="4">Usually nil but if these services are required allow at least $3,000.</td><td>$3,000</td><td>$3,000</td><td>Refer to Chapter K</td></tr>
<tr><td></td><td colspan="8">▪ Ongoing treatment refers to physiotherapy, chiropractic, osteopathic, remedial massage, pharmacy, domestic assistance etc.
• If any amount detailed in the above table is exceeded in the first 12 weeks, the Claims Service Provider must review the initial assessment ofthe claim and re-estimate the claim based on the available evidence.

Review the estimate for these amounts as follows:
• Level One and Level Two claim - re-estimate them to allow at least the amounts shown for Level Three;
• Level Three claims - re-estimate them to allow at least the amounts shown for Level Four; and
• Level Four claims - re-estimate them to allow at least the amounts shown for the 12-week review.</td><td></td></tr>
</table>

Benefits – No Current Work Capacity - continued

1.2: 12 Week Review

<table>
<tr><th>Weekly</th><th colspan="2">Medical, Hospital, Rehabilitation expenses</th><th>Investigation and Other expenses</th></tr>
<tr><td rowspan="4">The worker has no current work capacity even though the initial expected time off work was less than 12 weeks:

Increase the estimate to allow for the lesser of:

• a further 40 weeks of weekly payments, or to the first anniversary after retiring age

• plus an allowance for any unpaid or outstanding weekly benefit amounts.

Also, review the weekly benefit rate of compensation the worker should be receiving for each week they are off work and use the new amount to calculate the estimate.</td><td colspan="2">The estimate for medical, hospital and rehabilitation expenses should reflect those expenses for reasonably necessary treatment.
Use the amounts shown in the following table unless there is evidence that another amount is more appropriate.
Where the worker has no capacity for work …</td><td rowspan="4">Investigation costs

If an independent medical or other investigation may be required, allow as a minimum $2,000 and review the estimate as more information is received.

Other expenses

Consider also estimating, as appropriate, future costs of other compensation payments such as: aids and equipment; property damage; travel and accommodation; home care services; interpreter costs; etc.</td></tr>
<tr><td>Medical & treatment</td><td>$3,000</td></tr>
<tr><td>Hospital</td><td>Usually nil.
If required, allow at least $5,000.</td></tr>
<tr><td>Rehabilitation</td><td>If required but no referral has been made, allow $3,000.
If a referral has been made, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional $2,000.</td></tr>
<tr><td rowspan="4">The worker has not returned to work and the initial expected time off work is greater than 12 weeks:
If the worker has an injury for which the initial expected time off work is greater than 12 weeks, the Claims Service Provider must review the estimate at the end of thatperiod with that review regarded as part of the 12 week review. At this point, review the estimate as follows:

If the worker has no current work capacity:

• Increase the estimate to allow for the lesser of further 40 weeks of weekly compensation benefit, or to the first anniversary after retiring age

• plus an allowance for any unpaid or outstanding weekly benefit amounts.

Also, review the weekly benefit rate of compensation the worker should be receiving for each week they are off work and use the new amount to calculate the estimate.</td><td colspan="2">The estimate for medical, hospital and rehabilitation expenses should reflect those expenses for reasonably necessary treatment.

Use the amounts shown in the following table unless there is evidence that another amount is more appropriate.
Where the worker has no capacity for work …</td><td rowspan="4">Investigation costs

If an independent medical or other investigation may be required, allow as a minimum $2,000 and review the estimate as more information is received

Other expenses

Consider also estimating, as appropriate, future costs of other compensation payments such as: aids and equipment; property damage; travel and accommodation; home care services; interpreter costs; etc.</td></tr>
<tr><td>Medical & treatment</td><td>$3,000</td></tr>
<tr><td>Hospital</td><td>Usually nil.
If required, allow at least $5,000.</td></tr>
<tr><td>Rehabilitation</td><td>If required but no referral has been made, allow $3,000.
If a referral has been made, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional $2,000.</td></tr>
</table>

This Table must be read in conjunction with the Notes to this Chapter.

Benefits – No Current Work Capacity - continued

1.3: 26, 52, 78, 104 Week and Later Reviews

Weekly

The worker has no current work capacity:

Increase the estimate to reflect the allowances in the following table plus an allowance for any unpaid or outstanding weekly benefit amounts:

Where the worker has no capacity for work …	**Increase the estimate to allow the lesser of …**
26-week review	At least 104 weeks of incapacity; or to the first anniversary after retiring age
Review pre-injury average weekly earnings at 52 week review. After 52 weeks of weekly payments, overtime and shift allowances are excluded from pre-injury AWE.	
52-week review	At least four years of incapacity; or to the first anniversary after retiring age
78-week review	At least three and a half years of incapacity; or to the first anniversary after retiring age
104-week review	At least three years of incapacity; or to the first anniversary afterretiringage
Subsequent bi-annual reviews.	At least two years of incapacity. Unless the worker has a permanent impairment of 21% to 30 % in which case estimate through to the first anniversary after retiring age
Claims must be reviewed at 260 weeks to determine eligibility for ongoing weekly payments.	Estimate to the first anniversary after retiring age

Medical, Hospital, Rehabilitation expenses

The estimate for medical, hospital and rehabilitation expenses should reflect those expenses for reasonably necessary treatment.

Use the amounts shown in the following table unless there is evidence that another amount is more appropriate.

Where the worker has no capacity for work …

Medical & treatment	$4,000 per year of estimated incapacity
Hospital	Usually nil. If required, allow $5,000
Rehabilitation	If required but no referral has been made, allow $3,000. If a referral has been made, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional $2,000.

The above amounts also apply at the relevant review points for a worker who has reached the first anniversary after retiring age but is no longer in receipt of weekly payments and is receiving ongoing treatment for their work related injury up to two years (for 0-10% WPI) or five years (11-20% WPI) after reaching the first anniversary after retiring age. Workers with >20% WPI are entitled to ongoing treatment for their work-related injury for the duration of their life expectancy

Investigation and Other expenses

Investigation costs

If an independent medical or other investigation may be required, allow as a minimum $2,000 and review the estimate as more information is received.

Other expenses

Consider also estimating, as appropriate, future costs of other compensation payments such as: aids and equipment; property damage; travel and accommodation; home care services; interpreter costs; etc.

Notes:

- If at any point the worker's permanent impairment is assessed at not greater than 20% WPI then adjust the estimate so that the estimate will allow for a period of weekly payments up to 260 weeks of weekly payments of compensation inclusive of payments paid or to be paid.

- If at any point the worker has "no current work capacity" which is likely to continue indefinitely and a permanent impairment assessed at (or anticipated to be) greater than 20% WPI increase the estimate to the lesser of:

    - a further eight years of weekly payments, or
    - to the first anniversary after retiring age

- If at any point the Claims Service Provider makes a "work capacity decision" in accordance with section 43 of the 1987 Act which indicates a "capacity for work" and the worker accepts the "decision" then depending on the availability of suitable duties/employment, estimate according to either Chapter L – Work Capacity – At work or Chapter M - Work Capacity – Not at Work.

- If a worker seeks a "review" of a "work capacity decision" under section 287A of the 1998 Act the Claims Service Provider must maintain the estimate in accordance with the above Table until the conclusion of the review process.

Chapter K: Workers with Highest Needs

28. This Chapter applies to all workers with highest needs who have been assessed at or are anticipated to have permanent impairment greater than 30% Whole Person Impairment regardless of the work capacity status of the worker or the date of notification.

Case Managers should assess each claim on its individual merits and apply the most appropriate estimate based on the information known at each estimate review point.

If a worker's permanent impairment is subsequently assessed at not greater than 30% WPI - refer to the appropriate Chapter having regard to the worker's current certificate of capacity at the time of the assessment and estimate in line with that Chapter.

When reviewing an estimate for a person who is a worker with highest needs:

- check the accuracy of the weekly rate being paid and revise the estimate to ensure any calculationfor weekly payments reflects the most recent indexation of PIAWE benefits (amended every April and October),
- monitor any fundamental change in the worker's circumstances or medical condition that would necessitate a variation in the provision of services or expenses
- review permanent impairment entitlements under section 66 (1987 Act) - refer Chapter N. If the exact degree of permanent impairment is unknown, but there is an indication that the worker will suffer a degree of permanent impairment greater than 30% WPI, allow for an estimate of at least 31% WPI.

The suggested estimates in Table Two for medical, hospital, homecare, home modifications, etc areprovided as a guide until further information is obtained.

Note: Workers with Highest Needs (as well as Workers with High Needs) are entitled to reasonably necessary medical expenses for life. Estimates must reflect anticipated expenses.

Table Two: Workers with Highest Needs

Benefits –Workers with Highest Needs		
2.1. All Review Points		
Weekly	**Medical, Hospital, Rehabilitation expenses**	**Entitlements, Investigation and Other expenses**
The estimate must include the total amount of weekly payments a worker is entitled to be paid from the review point until the first anniversary after retiring age. Check the accuracy of the weekly rate being paid and revise the estimate to ensure any calculation for weekly payments reflects the most recent indexation of PIAWE benefits (amended every April and October),	• Workers who are permanently hospitalised - at least $300,000 a year for the worker's life expectancy; • workers in nursing homes - at least $200,000 a year for the worker's life expectancy; and • workers needing full time attendant home care - at least $200,000 a year for the worker's life expectancy. If evidence indicates the above amounts are too low, the Claims Service Provider must increase the estimate. The above amounts also apply at the relevant review points for a worker who has reached the first anniversary after retiring age but is no longer in receipt of weekly payments and is receiving ongoing treatment for their work related injury.	Permanent Impairment (Section 66 (1987 Act)), refer to ChapterN • expenses such as travel, house alterations, etc., allow at least $20,000 more if there is information showing that more will be required; • if any medical or other investigations are likely, allow at least $20,000, but review as new information is available; • expected legal expenses, refer to Chapter E; and • any other entitlements the worker may be eligible to receive.

Chapter L: Current Work Capacity

This Chapter applies to workers working for the same employer, or a different employer who meet atleast one of the following criteria:

- who have a current work capacity as a result of an injury and have an ongoing wage loss; or
- who have had a “work capacity decision” made in respect of their ability to work.

Claims Service Providers must base the estimate on

29. When estimating, the Claims Service Provider must always consider the worker’s capacity for work at the time of the review and assess the worker’s entitlements to weekly payments. The level of entitlement for weekly payments may vary depending on the number of hours a worker is capable of working and the amount of benefits already paid. Include in the estimate the total amount of weekly payments for the number of weeks the worker is expected to be off work. Refer to Table Three: Work Capacity – At Work.

    The level of permanent impairment is one of the drivers for estimating the duration of entitlements for weekly payments. Claims Service Providers must monitor any Whole Person Impairment assessment to ensure the correct estimate is applied.

    Employers and workers will need to provide information about the pre-injury average weekly earnings (PIAWE) to a Claims Service Provider to assess the actual economic loss. This information may be required for the initial assessment of loss or if ongoing benefits are being paid to a worker. If the actual economic loss is known or can be reasonably assessed, base the estimate on that amount. Otherwise, use the known information and pro-rata weekly earnings for estimating purposes. Review the estimate as new information is received.

Worker or employer does not claim weekly payments

30. If the worker is entitled to weekly payments, the Claims Service Provider must include the amount in the estimate regardless of whether or not the employer is claiming those benefits. The Claims Service Provider must maintain an estimate until the claim is finalised.

Considerations when reviewing a work capacity estimate

31. When reviewing an estimate for a person who has a work capacity:

    - check the accuracy of the weekly rate being paid, review wage reimbursement schedules and revise the estimate and ensure any calculation for weekly payments reflects the most recent indexation of PIAWE benefits (amended every April and October); and
    - monitor any fundamental variations in the worker’s actual economic loss as a result of changes incircumstances including the worker’s medical condition.

Change in Work Capacity

32. If at any point, there is a change in the worker’s work capacity or the employer is unable to provide suitable duties/employment for the worker, then refer as appropriate to either Chapter J – No Work Capacity or Chapter M - Work Capacity – Not at Work.

Work Capacity Decision

33. When a work capacity decision is made, the Claims Service Provider must:

    - amend the estimate to reflect the adjusted amount of weekly payments for the balance of the estimated period of incapacity (if any), plus an allowance for any unpaid or outstanding weekly benefit amounts at the review point, based on sound evidence, following appropriate issue of advice to the worker and expiration of the statutory periods (s80 of the 1998 Act);
    - at subsequent review points apply the timeframes applicable at that review point but use the amended rate in calculating the estimate.

Note: The estimate for weekly payments cannot be amended until the worker has been advised of the reduction and payments at the amended rate have commenced i.e. after the required period of notice.

Amending the estimate

34. The Claims Service Provider can reduce an estimate for a claim for weekly payments when the worker either returns to duties with no ongoing wage loss, or there is a decrease in the quantum of weekly entitlements. If the return to work is not sustained, review the claim in accordance with the relevant reviewpoint.

    The Claims Service Provider must review the estimate considering:

    - any future incapacity (e.g. future surgery, time loss for ongoing treatment, removal of internal fixatives, etc.),
    - medical or rehabilitation costs,
    - possible permanent impairment entitlements,
    - ensure the estimate is sufficient to pay any outstanding wage reimbursement schedules
    - whether allowances for investigation costs and other expenses are required. If so allow, allow as a minimum $2,000 and review the estimate as more information is received.
    - future costs of other compensation payments such as: aids and equipment; property damage; travel and accommodation; home care services; interpreter costs; etc

    Update the estimate upon receipt of additional information and review the estimate at the next review point.

Worker requires time off work after returning to work

35. After a period of return to work and the worker requires time off work, immediately review the estimate as per the current review point of Chapter J – No Current Work Capacity. For LPR customers consider if an estimate based on Table Five recovery timeframes or one based on other medical evidence on file can be applied.

Worker has returned to work with no wage loss but requires ongoing medical treatment

36. Where a worker has returned to work without further expected wage loss but there is an indication that ongoing medical treatment is required, allow a minimum of $1,500 for medical treatment.

    No allowance for hospital is generally required. If future hospital treatment is indicated, allow at least $5,000. If a referral has been made for rehabilitation, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional $2,000.

    Update the estimate upon receipt of additional information and review the estimate at the next reviewpoint.

    Refer to section 59A of the 1987 Act for time limits on entitlements to medical expenses (not applicable to exempt workers).

Table Three: Current Work Capacity – At Work

Benefits – Work Capacity – at work

3.1: Initial Estimate

Weekly

Allow for payments to cover the period the worker is entitled to benefits on the basis of sound evidence.

Note: If the worker has a "current work capacity" and returns to work within the timeframes for the type of injury in Table Five then for the initial estimate in this Chapter, consider applying the balance of Table Five.

If there is no sound evidence to support another estimate period, use the period shown in this Table plus an allowance for any unpaid or outstanding weekly benefit amounts:

Where the worker is back at work and is entitled to weekly payments …	**Initial estimate of at least the lesser of the allowances below orto the first anniversary after retiring age…**
less than or equal to four weeks after the date of the injury	four weeks of entitlement.
more than four, but less than or equal to eight weeks after the date of the injury	eight weeks of entitlement.
more than eight, but less than or equalto 12 weeks after the date of the injury	12 weeks of entitlement.
more than 12, but less than or equalto 26 weeks after the date of the injury	26 weeks of entitlement.
more than 26, but less than or equalto 52 weeks after the date of the injury	52 weeks of entitlement.
more than 52 weeks after the dateof the injury	78 weeks of entitlement.

Medical, Hospital, Rehabilitation expenses

The estimate for medical, hospital and rehabilitation expenses should reflect those expenses for reasonably necessary treatment.

Use the amounts shown in the following table unless there is evidence that another amount is more appropriate.

Where the worker is back at work and is entitled to weekly payments …

	No indication that ongoing treatment required	Indication that ongoing treatment required
Medical & treatment	$700	$1,500 plus $1,500 for each additional year of estimated incapacity
Hospital	Usually nil. If required, allow $5,000	
Rehabilitation	If required but no referral has been made, allow $3,000. If a referral has been made, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional $2,000.	

Investigation and Other expenses

Investigation costs

If an independent medical or other investigation may be required, allow at least $2,000 and review the allowance as you receive more information.

Other Costs

Consider estimating, as appropriate, future costs of othercompensation payments such as aids and equipment; property damage; travel and accommodation; home careservices; interpretation costs; etc.

This Table must be read in conjunction with the Notes to this Chapter.

Benefits – Work Capacity – at work - continued

3.2: 12, 26, 52, 104 Week and Later Reviews

Weekly

If the worker has a work capacity and is entitled to weekly payments at the relevant review point, the Claims Service Provider must review the estimate and ensure any calculation for weekly payments reflects the most recent indexation of benefits (amended every April and October) plus an allowance for any unpaid or outstanding weekly benefit amounts. Base the estimate on the following table:

Where the worker is backat work and is entitled to weekly payments …	**Include in your estimate an amount of the lesser of the allowances below or tothe first anniversary after retiring age…**
12 week review	At least 26 weeks at the benefit rate. However, if the worker has a "current work capacity" but the Table Five estimate is greater than 12 weeks and the worker returns to work within the timeframes for the type of injury in Table Five then for theinitial estimate for this Chapter, consider applying the balance of Table Five.
26 week review	At least 52 weeks at the benefit rate.
For injuries prior to 26 October 2018 review pre-injury average weekly earnings at 52 week review. After 52 weeks of weekly payments, overtime and shift allowances are excluded from pre-injury AWE. Monitor any application under s38 (3) of 1987 Act. For guidance on future estimates if a s38 (3) decision is made – refer to the Notes that accompany this Table.	
52 week review	At least 78 weeks at the benefit rate.
78 week review	At least 52 weeks at the benefit rate.
104 week review	At least 26 weeks at the benefit rate.
Benefits only applicable if worker has entitlement under s38 (3) of1987 Act - refer to the Notes that accompany this Table.	

Medical, Hospital, Rehabilitation expenses

The estimate for medical, hospital and rehabilitation expenses should reflectthose expenses for reasonably necessary treatment.

Use the amounts shown in the following table unless there is evidence that another amount is more appropriate.

Where the worker is back at work and is entitled to weekly payments …

Medical & treatment	$1,500 plus $1,500 for each year of estimated incapacity.
Hospital	Usually nil. If required allow $5,000.
Rehabilitation	If required but no referral has been made, allow $3,000. If a referral has been made, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional $2,000.

The above amounts also apply at the relevant review points for a worker who was on suitable duties/employment and has reached the first anniversary after retiring age but is no longer in receipt of weekly payments and is receiving ongoing treatment for their work related injury up to two years (for 0-10% WPI) or Five years (11-20% WPI) after reaching the first anniversary after retiring age. Workers with >20% WPI are entitled to ongoing treatment for their work-related injury for the duration of their life expectancy

Investigation and Other expenses

Investigation costs

If an independent medical or other investigation may be required, allow at least $2,000 and review the allowance as youreceive more information.

Other Costs

Consider estimating, as appropriate, future costs of other compensation payments such as aids and equipment; propertydamage; travel and accommodation; home care services; interpretation costs; etc.

<table>
<tr><th colspan="4">Benefits – Work Capacity – at work - continued</th></tr>
<tr><td>Subsequent bi-annual reviews</td><td>Allow an estimate so that the estimate will allow for a period of weekly payments up to 260 weeks of weekly payments of compensation inclusive of payments paid or to be paid.</td><td colspan="2" rowspan="2"></td></tr>
<tr><td>Claims must be reviewed at 260 weeks to determine eligibility for ongoing weekly payments.</td><td>If benefits are payable after 260 weeks - estimate to the first anniversary after retiring age.</td></tr>
<tr><td colspan="2" rowspan="4">Compensation Court and/or PIC Awards (including consent awards) – pending work capacity assessment</td><td colspan="2">The estimate for medical, hospital and rehabilitation expenses should reflect those expenses for reasonably necessary treatment.
Use the amounts shown in the following table unless there is evidence that another amount is more appropriate.
Where the worker is not back at work …</td><td rowspan="4">Investigation costs
If an independent medical or other investigation may be required, allow as a minimum $2,000 and review the estimateas more information is received

Other expenses
Consider also estimating, as appropriate, future costs of other compensation payments such as: aids and equipment; propertydamage; travel and accommodation; home care services; interpreter costs; etc.</td></tr>
<tr><td>Medical & treatment</td><td>$4,000 per year of estimated incapacity.</td></tr>
<tr><td>Hospital</td><td>Usually nil.
If required allow at least $5,000.</td></tr>
<tr><td>Rehabilitation</td><td>Generally not required, but if referral is made allowfor $3,000.
If a referral identifies rehabilitation assistance is appropriate, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional $2,000.</td></tr>
</table>

Notes:

- If at any point a worker who has a “current work capacity” and becomes entitled to continuation of weekly payments after 130 weeks by virtue of s38 (3) of the 1987 Act and the permanent impairment is assessed at not greater than 20% WPI then adjust the estimate so that the estimate will allow for a period of weekly payments up to 260 weeks of weekly payments of compensation inclusive of payments paid or to be paid.
- If at any point a worker who has a “current work capacity” and becomes entitled to continuation of weekly payments after 130 weeks by virtue of s38 (3) of the 1987 Act and permanent impairment is assessed at (or anticipated to be) greater than 20% WPI increase the estimate at subsequent review points to reflect the lesser of:
    - a further five years of weekly payments, or
    - to the first anniversary after retiring age.
- If at any point the worker is assessed as having a “current work capacity” which is likely to continue indefinitely and is assessed with a permanent impairment arisingfrom the injury of greater than 30% WPI refer to Chapter K –Workers with Highest Needs.
- If at any point the Agent/Insurer makes a “work capacity decision” in accordance with s43 of the 1987 Act which indicates a “capacity for work” different to the “currentwork capacity” then the Agent / Insurer must estimate the claim in accordance with the above Table.
- If a worker seeks a “review” of a “work capacity decision” under s287A of the 1998 Act the Agent / Insurer must maintain the estimate in accordance with the above Table until the conclusion of the review process.

Chapter M: Work Capacity – Not at Work

This Chapter applies to Workers who have a work capacity but whose employers are unable to provide them with suitable duties/employment.

If at any point the worker is assessed as having a "current work capacity" which is likely to continue indefinitely and is assessed with a permanent impairment arising from the injury of greater than 30% refer to Chapter K – Workers with Highest Needs.

Claims Service Providers must base the estimate on:

37. When estimating, the Claims Service Provider must always consider the worker's capacity for work at the time of the review and assess the worker's entitlements to weekly payments. The level of entitlement for weekly payments may vary depending on the number of hours a worker is capable of working and the amount of benefits already paid. Include in the estimate the total amount of weekly payments for the number of weeks the worker is expected to be off work. Refer to Table Four: Work Capacity – Not at Work.

    The level of permanent impairment is one of the drivers for estimating the duration of entitlements for weekly payments. Claims Service Providers must monitor any Whole Person Impairment assessment to ensure the correct estimate is applied.

    Review the estimate as new information is received. Employers and workers will need to provide information about the pre-injury average weekly earnings (PIAWE) to a Claims Service Provider to assess the actual economic loss. This information may be required for the initial assessment of loss or if ongoing benefits are being paid to a worker.

Worker or employer does not claim weekly payments

38. If the worker is entitled to weekly payments, the Claims Service Provider must include the amount in the estimate regardless of whether or not the employer is claiming those benefits. The Claims Service Provider must maintain an estimate until the claim is finalised.

Change in work capacity status and reviewing the estimate

39. Where the worker returns to work, review the claim and estimate in line with the relevant review point in Chapter L - Current Work Capacity – At Work. If at any point the worker is assessed as having "no current work capacity" review the claim and estimate in line with the relevant review point in Chapter J – No Current Work Capacity.

Work Capacity Decision

40. When a work capacity decision is made, the Claims Service Provider must:

    - amend the estimate to reflect the adjusted amount of weekly payments for the balance of the estimated period of incapacity (if any), plus an allowance for any unpaid or outstanding weekly benefit amounts at the review point, based on sound evidence, following appropriate issue of advice to the worker and expiration of the statutory periods*;*
    - at subsequent review points apply the timeframes applicable at that review point but use the amended rate in calculating the estimate

    Note: The estimate for weekly payments cannot be amended until the worker has been advised of the reduction and payments at the amended rate have commenced i.e. after the required period of notice.

Table Four: Work Capacity – Not at Work

<table>
<tr><th colspan="4">Benefits – Work Capacity – Not at Work</th></tr>
<tr><th colspan="4">4.1: Initial Estimate</th></tr>
<tr><th colspan="2">Weekly</th><th colspan="2">Medical, Hospital, Rehabilitation expenses</th><th>Investigation and Other expenses</th></tr>
<tr><td colspan="2">Allow for payments to cover the periods shown in this Table plus an allowance for any unpaid or outstanding weekly benefit amounts:</td><td colspan="2">The estimate for medical, hospital and rehabilitation expenses should reflect those expenses for reasonably necessary treatment.
Use the amounts shown in the following table unless there is evidence that another amount is more appropriate.
Where the worker has a work capacity but is not back at work…</td><td rowspan="6">Investigation costs
If an independent medical or other investigation may be required, allow at least $2,000 and review the allowance as you receive more information
Other costs
Consider estimating, as appropriate, future costs of other compensation payments such as aids and equipment; property damage; travel and accommodation; home care services; interpretation costs; etc.</td></tr>
<tr><td>If the worker has a work capacity but is not back at work…</td><td>Initial estimate of at least the lesser of the allowance below or to the first anniversary after retiring age…</td><td>Medical & treatment</td><td>$4,000 per year of estimated incapacity</td></tr>
<tr><td>less than 26 weeks after the date of the injury</td><td>At least 52 weeks of weekly payments at the appropriate rates</td><td>Hospital</td><td>Usually nil.
If required allow $5,000.</td></tr>
<tr><td>26 weeks and more but less than 52 weeks, after the date of the injury</td><td>At least 104 weeks of weekly payments at the appropriate rates.</td><td>Rehabilitation</td><td>If required but no referral has been made, allow $3,000.
If a referral has been made, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional $2,000.</td></tr>
<tr><td>greater than 52 weeks after the date of the injury</td><td>At least 78 weeks of weekly payments at the appropriate rates.</td><td colspan="2" rowspan="2"></td></tr>
<tr><td>104 weeks and more after the date of the injury</td><td>At least 26 weeks of weekly payments at the appropriate rates.</td></tr>
</table>

This Table must be read in conjunction with the Notes to this Chapter.

Benefits – Work Capacity – Not at Work - continued

4.2: 12, 26, 52, 78, 104 Week and Later Reviews

Weekly

Estimate for payments to cover the period the worker to be entitled to section 38 benefits on the basis of sound evidence. If there is no sound evidence, use the period shown in this table plus an allowance for any unpaid or outstanding weekly benefit amounts:

If the worker has a work capacity but is not back at work…	**Include in your estimate an amount of the lesser of the allowances below or to the first anniversary after retiring age…**
12 week review	at least 52 weeks of weekly compensation
26 week review	at least 104 weeks of weekly compensation
52 week review	78 weeks of weekly payments
For injuries prior to 26 October 2018 review pre-injury average weekly earnings at 52 week review. After 52 weeks of weekly payments, overtime and shift allowances are excluded from pre-injury AWE. Monitor anyapplication under s38 (3) of 1987 Act. For guidance on future estimates if a s38 (3) decision is made – refer to the Notes that accompany this Table.	
78 week review	52 weeks of weekly compensation
104 week review	26 weeks of weekly compensation
Benefits only applicable if worker has entitlement under s38 (3) of 1987 Act - refer to the Notes that accompany this Table.	
Subsequent bi-annual reviews	Allow an estimate so that the estimate will allow for a period of weekly payments up to 260 weeks of weekly payments of compensation inclusive of payments paid or to be paid.
Claims must be reviewed at 260 weeks to determine eligibility for ongoing weekly payments.	Estimate to the first anniversary after retiring age but only if WPI is greater than 20%.
Compensation Court and/or PIC Awards (including consent awards) – pending work capacity assessment	

Medical, Hospital, Rehabilitation expenses

Use the amounts shown in the following table unless there is evidence that another amount is more appropriate.

Where the worker has a work capacity but is not back at work…

Medical & treatment	$4,000 per year of estimated incapacity
Hospital	Usually nil. If required allow $5,000.
Rehabilitation	If required but no referral has been made, allow $3,000. If a referral has been made, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional $2,000.

The above amounts also apply at the relevant review points for a worker who is able to perform work (but the employer is unable to offer suitable duties/employment) and has reached the first anniversary after retiring age but is no longer in receipt of weekly payments and is receiving ongoing treatment for their work related injury up to two years (for 0-10% WPI) or five years (11-20% WPI) after reaching the first anniversary after retiring age. Workers with >20% WPI are entitled to ongoing treatment for their work-related injury for the duration of their life expectancy.

Investigation and Other expenses

Investigation costs

If an independent medical or other investigation may be required, allow at least $2,000 and review the allowance as you receive more information

Other costs

Consider estimating, as appropriate, future costs of other compensation payments such as aids and equipment; property damage; travel and accommodation; home care services; interpretation costs; etc.

Notes:

- If at any point a worker who has a “current work capacity” and becomes entitled to continuation of weekly payments after 130 weeks by virtue of section 38 (3) of the 1987 Act and the permanent impairment is assessed at not greater than 20% WPI then adjust the estimate so that the estimate will allow for a period ofweekly payments up to 260 weeks of weekly payments of compensation inclusive of payments paid or to be paid.
- If at any point a worker who has a “current work capacity” and becomes entitled to continuation of weekly payments after 130 weeks by virtue of section 38 (3) of the 1987 Act and permanent impairment is assessed at (or anticipated to be) greater than 20% increase the estimate at subsequent review points to retiringage.
- If at any point the Claim Service Provider makes a “work capacity decision” in accordance with section 43 of the 1987 Act which indicates a “capacity for work” different to the“current work capacity” and the employer does not provide suitable duties/employment then the Agent / Insurer must estimate the claim in accordance with the above Table.
- If a worker seeks a “review” of a “work capacity decision” under s287A of the 1998 Act the Agent / Insurer must maintain the estimate in accordance with theabove Table until the conclusion of the review process.
- Entitlement to medical expenses cease two years after entitlements to weekly payments cease for workers with 0-10% WPI or five years for workers with 11-20% WPI. The entitlement to medical expenses for workers with >20% WPI remains for the duration of their life expectancy.

Chapter N: Permanent Impairment (Section 66) Entitlements

Refer to the SIRA Benefits Guide for relevant amounts payable based on the estimated or assessed Whole Person Impairment.

41. Any claim by the worker for benefits under section 66 of the 1987 Act, must include relevant particulars of the claim as outlined in Part 8 of the SIRA Workers Compensation Guidelines. Further the Claims Service Provider must administer the claim in accordance with these Guidelines.

    Payment for permanent impairment can only be made where the assessed amount is greater than 10% WPI or at least 15% WPI for a psychological injury,

    Staff of Claims Service Providers who estimate for entitlements under section 66 of the 1987 Act must be familiar with the SIRA Guides for the Evaluation of Permanent Impairment current at the time of assessment.

    The level of permanent impairment is one of the drivers for estimating the duration of entitlements for weekly payments. Therefore, if the level of permanent impairment is assessed at or anticipated to be greater than 20% or 30% the estimate for weekly payments must be reviewed to ensure entitlements are calculated correctly – refer to Chapters J, K, L and M of this document.

    Note: if the permanent impairment relates to hearing loss - refer to Chapter O - Hearing Impairment (Permanent Loss of Hearing) of this document.

Types of injury to consider where s66 entitlements may occur

42. Claims Service Providers should not routinely estimate for permanent impairment for soft tissue injuries. Similarly, unless a dislocation requires surgery an estimate should not be applied.

    An estimate must be considered where the injury is one of the following and the permanent impairment has been assessed at or is likely to be greater than 10% as indicated by the SIRA Guides for the Evaluation of Permanent Impairment:

    - amputation;
    - crush injuries;
    - surgery to the back, neck, shoulders, joints or limbs;
    - injury involving multiple body systems;
    - severe burns;
    - head injuries;
    - spinal cord injuries; or
    - psychological injuries (must be at least 15% WPI).

Timing of estimate and evidence required for section 66 entitlements

43. Claims Service Providers must consider the likelihood of a permanent impairment at the initial estimated and apply an estimate under section 66 of the 1987 Act if information indicates the worker may have an entitlement to payment for a permanent impairment. In addition, the estimate under section 66 (1987 Act) must be reviewed whenever evidence comes to hand that either comments on, confirms the likelihood of or quantifies a permanent impairment.

    If the exact degree of permanent impairment is unknown, but there is an indication that the worker will suffer a degree of permanent impairment greater than 10% WPI, a nominal estimate of 11% is required until more accurate information becomes available.

If the exact degree of permanent impairment for a psychological injury is unknown, but there is an indication that the worker will suffer a degree of permanent impairment of at least 15% WPI, a nominal estimate of 15% is required until more accurate information becomes available.

The estimate must be reviewed and/or maintained at subsequent review points until information either confirms the permanent impairment is greater than 10% WPI or at least 15% WPI for psychological injuries or indicates otherwise.

This evidence may be available from:

- an assessment of the nature and severity of the injury as reported by the worker / employer having regard to the SIRA Guides for the Evaluation of Permanent Impairment for the appropriate body system/s,
- medical reports that confirm the nature and severity of the injury,
- a report by a medical specialist trained in the SIRA Guides for the Evaluation of Permanent Impairment for the appropriate body system/s that states the degree of permanent impairment is assessed at or anticipated to be greater than 10% WPI or at least 15% WPI for a psychological injury,
- an independent medical examiner instructed by the Claims Service Provider that states the degree of permanent impairment is assessed at or anticipated to be greater than 10% WPI or greater than 15% WPI for a psychological injury,
- the receipt a of claim from a worker with relevant particulars claiming entitlements under section 66 (1987 Act); and
- other relevant information.

It is not appropriate for a Claims Service Provider to delay applying an estimate under section 66 (1987 Act) pending the receipt of either a formal assessment of the permanent impairment or claim made by worker under section 66 (1987 Act).

Other amounts to include in the initial section 66 estimate

44. Include in the estimate an allowance for medical assessment costs (as per the gazetted SIRA guidelines on Independent Medical Examinations and Reports), legal costs (as per Schedule 6 of the Workers Compensation Regulation 2016 (NSW)).

Medical Assessment Certificate (MAC) from the Personal Injury Commission (PIC)

45. If there is an assessment provided in a MAC from the PIC, the estimate should be based on the assessment of permanent impairment unless the assessment is less than 11% WPI. In that case the estimate should be reduced to zero.

Where the approved medical specialist (AMS) has declined to make an assessment because the AMS is not satisfied that the impairment is permanent and that the degree of permanent impairment is not fully ascertainable the assessment is to be maintained at the amount applied by the Claims Service Provider before the medical dispute was commenced.

Matter referred for independent medical examination

46. Where the Claims Service Provider refers the worker to an Independent Medical Examiner for assessment of permanent impairment the estimate is to be maintained as required by Rule 43 until the report is received.

Once the report is received the estimate must be reviewed to consider all medical information on file.

If there is a consensus of medical opinion that the permanent impairment is less than 11% WPI, reduce the estimate to zero.

If there is no consensus of medical opinion and/or medical reports on file indicate that the impairment is permanent but the degree of permanent impairment is not fully ascertainable at this time, the estimate as required by Rule 43 is to be maintained.

Research required prior to reducing an estimate or making a payment

47. The Claims Service Provider must request the worker provide details of any previous settlements or judgments. The relevant settlements and judgments include previous claims under section 66 (1987 Act), exit commutations and common law settlements and judgments.

    Any estimate or payment must be reduced by the previous settlement and/or judgments.

Other factors to consider when calculating or reviewing the estimate

48. The Claims Service Provider must check for the following factors:

- recovery action, refer to Chapter D - Recoveries;
- expected legal expenses, refer to Chapter E – Disputed and litigated matters;
- travel and accommodation expenses for the worker to attend medical examinations; and
- wage loss while attending medical examination.

Chapter O: Hearing Impairment (Permanent Loss of Hearing)

This Chapter applies to workers who claim a permanent loss of hearing to their employer on or after 19 June 2012.

Hearing Loss Threshold

49. Before being entitled to lump sum compensation for hearing loss, the worker's hearing loss must be assessed as being at least 11% WPI after relevant deductions.

    Any claim by the worker for benefits under section 66 of the 1987 Act, must include relevant particulars of the claim as outlined in Part 8 of the SIRA Workers Compensation Guidelines. Further the Claims Service Provider must administer the claim in accordance with these Guidelines.

    If the worker's current employer is a noisy employer, the date of injury is the date the worker gave notice of a loss of hearing to the employer. If the worker is no longer employed by a noisy employer, the date of injury is the last day the worker was employed by the most recent noisy employer.

What estimate to apply?

50. Estimate the hearing loss on the basis of the information contained in the worker's claim together with allowances (if necessary) for medical assessment costs (as per the gazetted SIRA guidelines on Independent Medical Examinations and Reports), investigative costs, travel expenses and hearing aids if indicated.

    Any estimate must be maintained until the conclusion of the assessment process.

    If a worker's hearing loss is assessed as being less than the 11% threshold, the worker remains entitled to be compensated for the cost of the assessment.

Matter referred for independent medical examination

51. Where the Claims Service Provider refers the worker to an Independent Medical Examiner for assessment of permanent impairment the estimate is to be maintained as required by Rule 50 until the report is received.

    Once the report is received the estimate must be reviewed to consider all medical information on file.

    If a dispute notice is issued, then the estimate as required by Rule 50 is to be maintained for three months.

Medical Assessment Certificate (MAC) from the Personal Injury Commission (PIC)

52. If the matter is referred to the PIC for a MAC assessment the estimate as required by Rule 50 is to be maintained pending outcome of the MAC

    If there is an assessment provided in a MAC from the PIC, the estimate should be based on the assessment of permanent impairment unless the assessment is less than 11% WPI. In that case the estimate should be reduced to zero.

Research required prior to reducing an estimate or making a payment

53. The Claims Service Provider must request the worker provide details of any previous settlements orjudgments. The relevant settlements and judgments include previous claims under section 66 of the 1987 Act, exit commutations and common law settlements and judgments.

    Any estimate or payment must be reduced by the previous settlement and/or judgments.

Other factors to consider when calculating or reviewing the estimate

54. The Claims Service Provider must check for the following factors:

- recovery action, refer to Chapter D - Recoveries;
- expected legal expenses, refer to Chapter E – Disputed and litigated claims.;
- travel and accommodation expenses for the worker to attend medical examinations; and
- wage loss while attending medical examination.

Hearing Aids

55. If the worker's hearing loss is assessed at greater than 6% binaural loss of hearing and hearing aids have been recommended by an appropriately qualified person, then an estimate for hearing aids in accordance with the *Workers Compensation (Hearing Aids Fees) Order 2022*, as updated from time to time, is to be applied. This estimateis to be applied regardless of whether the worker met the 11% impairment threshold.

Chapter P: Table Five: Minimum Weekly Compensation Estimate for Certain Injuries

Aim of Table Five

56. Table Five provides a general guide only as to the minimum period to include as the estimate for weekly compensation payments for certain injuries. A sound decision-making process must be undertaken and Table Five only used if no other information is available. In the absence of other evidence, the Claims Service Provider should use the periods contained in Table Five, with the information specific to the worker's situation, to make the initial estimate.

Worker's injury is not listed

57. If the worker's injury is not listed, base the initial estimate on the scenario that is reasonably likely to arise. The Claims Service Provider must align an injury type in Table Five that is similar to the worker's injury.

Initial Estimate for Weekly payments

58. The period for each injury shown in the table attached to Table Five represents the initial financial estimate to be applied for weekly payments for those injury types. For those workers who do not return to work within the initial estimate period, the Claims Service Provider must base the ongoing weekly compensation estimate on the evidence available and estimate in accordance with the appropriate Chapter of this Manual.

Effect of suitable duties availability on the worker's estimated return to work

59. The Claims Service Provider must include the availability of suitable duties/employment in the decision-making process when estimating when a worker is likely to return to work.

Table Five: Minimum Weekly Compensation Estimate for Certain Injuries

Bodily Location and Injury Type	Minimum Estimate
GROUP ONE: HEAD (includes cranium, eye, ear, mouth, nose, and face)	
Fracture of skull (without brain injury)	Six weeks
Fracture of jaw (without dislocation)	Six weeks
Fracture-dislocation of jaw	12 weeks
Concussion	One week
Serious head injuries (including closed/open head and brain injuries, severe facial injuries involving face, nose and/or ear)	Refer to Chapter K
Eye	
Major burn/thermal injury	26 weeks
Moderate thermal or chemical burn	Six weeks
Foreign body (corneal) and abrasions	Two weeks
Foreign body (intraocular)	6 weeks
Conjunctivitis/chemical irritation	One week
Contusions/bruising	One week
Retinal detachment	6 weeks
Ear	
Perforated ear drum	Two weeks
GROUP TWO: NECK	
Whiplash associated disorder (WAD) without radicular pain	Four weeks
Whiplash associated disorder (WAD) with radicular pain	12 weeks
Contusion/bruising/sprains	Four weeks
Fracture:	
to vertebral body	12 weeks
to spinous or transverse process	Six weeks
Fracture – dislocation	26 weeks
Fracture with spinal cord injury	Refer to Chapter K
GROUP THREE: TRUNK (includes upper/lower back, chest, abdomen, and pelvic region)	
Acute or recurrent back pain (non-radicular)	Four weeks
Radicular back pain	12 weeks
Fracture:	
of vertebral body	12 weeks
of transverse or spinous process	Six weeks
of sacrum	Four weeks
of coccyx	Four weeks
Contusion/bruising (upper/lower back)	Four weeks
Chest/thorax:	
Closed rib fracture	Four weeks
Fracture with complications (e.g.: pneumothorax)	12 weeks
Contusion	One week
Strain – intercostal muscles	One week
Abdomen and pelvic region	
Hernia with repair by suture	Eight weeks
Hernia with tension free or laparoscopic repair	Four weeks
Fracture of pelvis (without surgery)	12 weeks
Fracture of pelvis (with surgery)	26 weeks

GROUP FOUR: UPPER LIMB (including shoulder)	
Shoulder:	
Dislocation/subluxation (initial)	Six weeks
Dislocation/subluxation (recurrent)	Ten weeks
Rotator cuff /scapular muscle (cumulative injury)	Eight weeks
Rotator cuff/scapular muscles (traumatic injury)	12 weeks
Synovitis/tendonitis/ligament sprain	Six weeks
Other sprains/strains/contusions	Four weeks
Fracture – simple	Eight weeks
Fracture – complex (no surgery)	12 weeks
Fracture – complex (with surgery)	16 weeks
Bursitis/impingement syndrome	Eight weeks
Traumatic arthritis (acute)	Six weeks
Upper arm	
Fractured humerus	Eight weeks
Tendon rupture	12 weeks
Tendonitis/sprain/contusion	Six weeks
Elbow	
Epicondylitis/bursitis/sprains	Six weeks
Fracture – simple	Eight weeks
Complex fracture/fracture-dislocation	12 weeks
Ulnar nerve entrapment	12 weeks
Traumatic arthritis (acute)	Six weeks
Forearm	
Fracture – proximal radius/ulna	Eight weeks
Sprain/contusion	Four weeks
Wrist flexor/extensor tendon rupture	12 weeks
Wrist	
Tenosynovitis/sprain/contusion	Six weeks
Fracture – scaphoid	12 weeks
Fracture – carpal (not scaphoid)	Eight weeks
Carpal tunnel syndrome	Eight weeks
Fracture-dislocation	12 weeks
Traumatic arthritis (acute)	Six weeks
Hands/fingers/thumb	
Fracture – simple (metacarpals/phalanges)	Six weeks
Fracture – complex with surgery	12 weeks
Sprain/contusion – finger/thumb	Four weeks
Tenosynovitis/De Quervain syndrome	Six weeks
Tendon rupture	12 weeks
Traumatic amputation - finger	12 weeks
GROUP FIVE: LOWER LIMB (including hip)	
Hip	
Fracture/dislocation (no surgery)	12 weeks
Fracture/dislocation (with surgery)	20 weeks
Tendonitis/bursitis	Six weeks
Traumatic arthritis (acute)	Six weeks
Sprain/contusion	Four weeks
Total hip replacement	26 weeks
Upper leg	
Thigh muscle strain	Two weeks
Fractured femur	12 weeks
Traumatic amputation	Refer to Chapter K
Knee	
Fracture – simple	Eight weeks
Fracture – complex (with surgery)	26 weeks

Dislocation (patella)	Eight weeks
Knee replacement	26 weeks
Sprain/contusion (collateral ligaments)	Four weeks
Cruciate ligament sprain	Six weeks
Cruciate ligament rupture (with surgery)	12 weeks
Meniscus injury with surgery	Six weeks
Patella tendonitis	Four weeks
Patella bursitis	Eight weeks
Patella disorders	Five weeks
Traumatic arthritis (acute)	Six weeks
Lower leg	
Tendonitis – (including Achilles tendonitis)	Six weeks
Fracture – tibia	12 weeks
Fracture – fibula	Eight weeks
Achilles rupture	20 weeks
Ankle	
Fracture – simple	Eight weeks
Fracture – complex (with/without dislocation)	12 weeks
Sprain/contusion	Four weeks
Traumatic arthritis (acute)	Six weeks
Foot/toes	
Fracture – tarsal/metatarsal	Eight weeks
Fracture – phalanges	Six weeks
Sprain/contusion	Four weeks
Plantar fasciitis	Six weeks
Traumatic arthritis	Six weeks
Traumatic amputation – toe	12 weeks
GROUP SIX: NON-PHYSICAL LOCATIONS	
Psychological system (including: Anxiety-related disorders; Depressive disorders; Adjustment disorders)	12 weeks
GROUP SEVEN: OTHER INJURIES/DISEASES	
Toxic reactions (e.g.: bee sting)	One week
Paraplegia	Refer to Chapter K
Quadriplegia	Refer to Chapter K
Skin diseases (e.g.: reactive dermatitis)	Four weeks
Burns (localised on limb/hand/foot/trunk/face)	
First degree	Four weeks
Second degree	Six weeks
Third degree	26 weeks
Severe burns (multiple locations)	Refer to Chapter K
Peripheral nerve injuries	12 weeks
Lacerations/puncture wounds	
Simple	One week
Complex (nerves or tendons involved)	12 weeks
Infection	
Superficial	Two weeks
Deep	Eight weeks

Addendum

For claims managed on the icare claims system, manual estimation is only required for LPR claims from the 12-week review point on and for non LPR policies after 260 weeks. The icare claims system will automatically apply estimates for LPR policies for the initial estimate only and for all non-LPR policies from the initial estimate to 260 weeks. The initial LPR estimate should be reviewed and updated where required. It is recommended that activities are created manually for LPR claims to update the estimate at the relevant review points but from date of injury - Refer to Rule 12.

Delay in notification of the injury on claims attached to an LPR customer

If the initial notification of the injury to the Claims Service Provider is more than five days but less than six weeks after the worker notified the employer of the injury, estimate in accordance with Table Five and/or the appropriate Table. If notification of the injury is delayed by six weeks or greater, use the relevant review point outlined in the following table to determine the estimate, unless medical evidence supports an alternative estimate:

If the claim is reported …	**Use the following review points …**
Six weeks and greater after the date of the injury	12 week review
12 weeks and greater after the date of the injury	26 week review
26 weeks and greater after the date of the injury	52 week review
52 weeks and greater after the date of the injury	104 week review

Examples of the next review point – when the notification of injury has been delayed

Note: Injuries reported more than 12 weeks after the date of injury are to be estimated as described in this Manual despite the application of Section 44B (5) of the 1987 Act regarding certificates of capacity. The estimate may be modified once the Claims Service Provider has completed investigations and determined that the worker has no entitlement to the weekly payments. The estimate is to reflect the revised weekly payments for the balance of the estimate period.

icare™
Insurance and Care NSW

Treatment Decision Making Framework

June 2022

Document / Revision control

Version	Date	Author / changes made by	Comments / Changes to Document
Version 1	1 June 2022	Chief Medical Officer	First release of Treatment Decision Making Framework

Contents

1. A framework for treatment decision making

Recent reviews have identified inconsistent treatment decision making is leading to increased utilisation and driving medical cost increases in our schemes without improving customer outcomes. icare is committed to delivering best practice treatment decisions across the Nominal Insurer (NI) and Treasury Managed Fund (TMF) workers compensation schemes that are outcome focussed, consistent and compliant. To this end, and in collaboration with Claims Service Providers (CSPs), icare developed this Treatment Decision Making Framework (referred to as the 'Framework'). The Framework sets the expectation for icare and CSPs to implement practices and processes in their business that will enable and deliver on the outcomes described in this framework to achieve healthcare best practice.

The intent of the Framework is to:

- provide a foundation for further co-design and consultation to develop solutions to achieve the desired 'outcomes' laid out in the Domains, as well as the 'Enablers of Success', and
- facilitate broader communication and consultation with Regulatory agencies, service providers, healthcare peak bodies, and the general public.

1.1 icare's vision for treatment decisions

icare's vision for treatment decision making involves ensuring outcome focussed, consistent and compliant treatment decisions to support our customers to recover and return to work and health as follows:

- **Outcome focussed:** Treatment decisions consider the broad range of factors that determine the individual needs of the worker, the effectiveness and efficiency of care, and are in line with the considerations outlined in SIRA's Value Based Healthcare Outcomes Framework.
- **Consistent:** Treatment decisions are made in a consistent way between the Nominal Insurer, Claims Service Providers (CSPs) and the Treasury Managed Funds (TMF) agents. The experience is also consistent for workers, treatment providers and other stakeholders.
- **Compliant:** Treatment decisions meet legislative requirements and SIRA guidelines.

1.2 Ownership and maintenance of the framework

icare will own the Framework and assume responsibility for maintaining, updating and communicating the Framework as circumstances change, such as changes to the Workers Compensation legislation, SIRA guidelines, or the SIRA Value Based Healthcare Outcomes Framework and Implementation Plan.

1.3 Structure of the framework

This Framework sets out:

1. **Guiding principles** - the principles underpinning the Framework that should guide all decision makers.
2. **The Decision-Making Network** – The stakeholders that play a role in treatment decision making.
3. **Inputs to treatment decisions** – The inputs that factor into treatment decisions, such as compliance requirements and considerations supporting value-based healthcare outcomes.
4. **Enablers of Success** – Defines what front line claims staff must be enabled to achieve.
5. **The Domains of Focus** – The areas that are important to treatment decision making, including the target outcomes within each.
6. **Outcomes** – clearly stated outcomes required to be achieved for best practice treatment decision making.

1.4 Guiding Principles

The following principles underpin the Framework and should be considered by all decision makers and those designing improvements to achieve the outcomes laid out in this Framework.

1. **Balanced and goal focussed** – Decisions aim to achieve optimal health, function, participation and return to work outcomes, aligned with the individual's goals and delivery of value based care.
2. **Collaboration and empathy** – Decisions include the worker in the process, consider their individual circumstances, and are communicated with empathy.
3. **Informed and accountable** – Decisions are made in accordance with legislation, SIRA guidelines, regulatory frameworks, and evidence-based healthcare.
4. **Professional and efficient** – The rationale and mechanisms for decisions are transparent and fair, and are delivered in a timely way.

1.5 The Decision-Making Network

While the Case Manager is the primary decision maker for treatment approvals and declinatures, various stakeholders play a role in the management of a claim, especially in cases of complex treatment decisions where additional support and reviews are required. It should also be noted that:

A. job titles may vary between CSPs, however the responsibilities of the roles should be consistent, and

B. that differences currently exist between the NI and TMF schemes in the stakeholders that are involved and their responsibilities, however this may be revised in the future.

The table below details the stakeholders that play a role in treatment decisions:

Type	Stakeholder / Actor	Role in Treatment Decision	Description
Claims Service Provider (CSP)	Case Manager (CM)	Decision Maker	Responsible for collecting and assessing information related to a treatment request to determine if it is reasonably necessary, and for maintaining communication with claim stakeholders to facilitate an outcome-focussed claim strategy.
	Injury Management Specialist (IMS)	Support and peer review for the decision maker (primary) Decision Maker (if escalated)	Determine if treatment is reasonably necessary, particularly for complex or novel treatments.
	Technical Specialist (TS)	Support and peer review for the decision maker (especially for declinatures and reviews) Decision Maker (if escalated)	Determine if treatment is eligible under compliance rules and advise the Case Manager. Decision rights may vary between NI and TMF schemes.
	Team Lead (TL)	Support and peer review for decision maker (primary) Decision Maker (if escalated)	Provides support to the Case Manager relating to treatment decisions, particularly in the absence of the IMS. Decision rights may vary between NI and TMF schemes.

A framework for treatment decision making (continued)

Type	Stakeholder / Actor	Role in Treatment Decision	Description
icare	Medical Support Panel (MSP)	Support for the decision maker	Provide clinical recommendations particularly for complex claims and emerging treatments.
	Technical Claims Lead	Support for the decision maker (TMF scheme)	Provide oversight and review whether the requested treatment is appropriate in accordance with the Decision Rights Framework
Customers	Worker	Treatment receiver	The subject of the claim who receives the requested treatment. Treatment requests may be sent to the CSP directly by the treatment provider or via the worker.
	Employer / Broker	Informed of planned and undertaken treatments	The Case Manager must keep the Employer abreast of the claim strategy, including planned treatments, progress in the worker's recovery, etc.
Treatment Providers	Nominated Treating Doctor (NTD)	Treatment requestor and provider	Usually a General Practitioner who is a central point of contact on a claim and responsible for activities such as issuing updated Certificates of Capacity for the worker.
	Nominated Treating Specialist (NTS)	Treatment requestor and provider	Provides specialist treatment to the worker and can act as the NTD with agreement from the worker.
	Other Treatment providers	Treatment requestor and provider	Can include other treatment providers, such as Allied Health providers.
Independent Reviewers	Independent Medical Examiner (IME)	Treatment Advisor	An appropriately qualified and experienced medical practitioner who conducts an assessment to help resolve an issue in injury or claims management[1].
	Injury Management Consultant (IMC)	Capacity Advisor	Injury Management Consultants are facilitators who help overcome complex return to work and injury management barriers in order to achieve the best possible outcome for workers[2].
	Independent Consultant (IC)	Treatment Advisor	Provides advice to the Case Manager for Allied Health treatment decisions and whether they are 'reasonably necessary' according to legislation.

1 https://www.sira.nsw.gov.au/workers-compensation-claims-guide/understanding-the-claims-journey/medical-and-related-services/independent-medical-examinations
2 https://www.sira.nsw.gov.au/for-service-providers/A-Z-of-service-providers/injury-management-consultants

1.6 Inputs to consider for treatment decisions

1.6.1 The SIRA Value Based Healthcare Outcomes Framework

On 20 July 2021 SIRA published the Value-Based Healthcare Outcomes Framework to progress the implementation of value-based care in the workers compensation and CTP schemes. The document states:

"SIRA is committed to implementing value-based healthcare within the WC [Workers Compensation] and CTP [Compulsory Third Party] schemes. Value-based healthcare will support recovery, and improve return to activity, return to work and quality of life outcomes for people injured at work and on the road.

To determine whether value is being delivered from healthcare expenditure, health outcomes must be measured and understood. The Value-Based Healthcare Outcomes Framework is fundamental to achieving this."

SIRA's framework cites NSW Health's "four essentials of value", otherwise known as the "Quadruple Aim" for delivery of healthcare services[3]:

1. Health outcomes that matter to patients,
2. Experiences of receiving care,
3. Experiences of providing care, and
4. Effectiveness and efficiency of care.

In this vein the following outcomes as part of the Value Based Healthcare Outcomes Framework (refer to the SIRA website for the latest version and further detail):

1. Physical and mental health of the worker
2. Wellbeing of the worker and its impact on return to activities/ work and quality of life
3. Injured person healthcare experience and accessibility
4. Safety and quality of healthcare
5. Provider expertise, delivery and experience
6. Effectiveness and efficiency of healthcare

ref, Value-Based HealthCare Outcomes Framework for the NSW Workers Compensation and Motor Accident/Injury Compulsory Third Party Schemes, 28 July 2021; SIRA

3 https://www.health.nsw.gov.au/Value/Pages/about.aspx

1.7 Enablers of Success

The claims frontline staff sit at the heart of the Treatment Decision Making Framework (TDMF). To achieve best practice treatment decision making, Case Managers must be supported by the following Enablers of Success. These enablers are empowered through training, system and process support[4]. Training for these enablers will be achieved through adherence to the Professional Standards Framework[5], which describes core competencies regarding Positive Connections, Empowered Leadership, Holistic Case Management, Scheme Regulation, Bringing Best Self and Business Enablers.

Case Managers understand the quality metrics and act upon timely insights to ensure consistent quality of decisions

Case Managers can use the systems and tools to easily and reliably enhance decision making capability, and enable the transparency of decision rationale

Case Managers can interpret legislative requirements and have sufficient time to work within the compliance timeframes to manage the nuances and complexity of treatment decision making effectively

Case Managers are empowered to assess requests confidently and know how to leverage support teams to determine 'reasonably necessary' and make soundly based, outcome focussed decisions

Case Managers can gather and interpret the right information to consider the worker's holistic needs and make well supported decisions

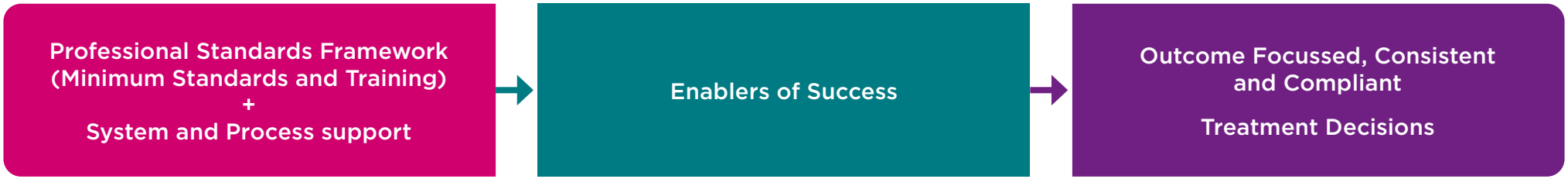
4 Refer to infographic 1.7.1
5 Please refer to the Professional Standards Framework added as Appendix C

Enablers of success identifying capability, task and goal

The below table shows the enablers of success and identifies the core capabilities and tasks required of a Case Manager to achieve the goals of making outcome-based decisions. These are in alignment with core competencies achieved through the Professional Standards Framework.

As a Case Manager...	Capability Case Managers can...	Task Case Managers need to...	Goal To achieve...
1	Case Managers can interpret legislative requirements and	have sufficient time to work within the compliance time frames	to manage the nuances and complexity of treatment decision making effectively
2	Case Managers are empowered to assess requests confidently and	know how to leverage support teams	to determine Reasonably Necessary and make outcome based decisions
3	Case Managers can gather and interpret the right information to	consider the worker's holistic needs	and make well supported decisions
4	Case Managers can use the systems and tools to	easily and reliably	enhance decision making capability and enable the transparency of decision rationale
5	Case Managers understand the quality metrics and	I act upon timely insights	to ensure consistent quality of decisions

1.7.1 The input stream to enable TDMF success



2. Domains of Focus

Five Domains of Focus have been identified as key to uplifting treatment decision making and achieving the intended outcomes of the framework. Note that the intended outcomes do not prescribe how they will be achieved – this is to be determined through further collaboration between icare, the CSPs and potentially other stakeholders, taking feasibility, benefits and other impacts into account.

Each stakeholder will play a varied role to collectively achieve the outcomes of the framework. The 'responsible' columns to the right of the below table are indicative of who does play a role in achieving the outcome and is not suggesting equal obligations to deliver on the outcome.

Domain	Outcome	icare	CSPs	Providers	Employer & Worker
D1 Governance The fundamental tenets that we must operate within for Treatment Decision Making	**Clear understanding of 'reasonably necessary' across the Decision-Making Network** • Ensure the Decision-Making Network are up to date with the latest legislation and guidelines regarding reasonably necessary and can demonstrate understanding per the icare standards (see Appendix A)	✓	✓		
	Compliance timeframes are met	✓	✓	✓	
	Treatment decisions must be outcome focussed • Drive Treatment Decisions that consider the whole worker and outcomes in line with the principles of the Value Based Health Care Outcomes Framework • Ensure the nationally endorsed Clinical Framework is applied when treating people (see Appendix B)	✓	✓	✓	
	Embedding evidence-based clinical practice to maximise recovery	✓	✓	✓	

Domains of Focus (continued)

Domain	Outcome	icare	CSPs	Providers	Employer & Worker
D2 People & Accountability All people in the decision-making network need to understand their role, the mechanics of the scheme and apply these to the decision they make and/or the services they provide to our customers.	**Clear understanding of the roles and accountabilities of the Decision-Making Network** • All members of the treatment decision-making network, including internal staff, and external members such as treatment providers and workers, understand their roles and accountabilities in the workers compensation scheme. • CSPs are empowered to structure their Claims Management teams as required provided the roles and accountabilities are consistent with the framework and the decision rights requirements.	✓	✓	✓	✓
D3 – Professional Standards & Capability Decision Makers manage a wide group of stakeholders across multiple cases. Decision Makers need communication and influencing training along with a baseline of health literacy to be proficient in treatment decision management.	**Case Managers are empowered to confidently assess and make soundly based, outcome focussed decisions** • Ensure a baseline of health literacy • Ensure training in CM capabilities and personal attributes to be successful in delivering high quality treatment decision making and case management (SIRA Standard 34 & icare Professional Standards) • Ensure CMs have capability to influence Treatment Providers and workers towards best practice self-management • Ensure CMs are confident and empowered through competence to engage the Decision-Making Network	✓	✓		

Domains of Focus (continued)

Domain	Outcome	icare	CSPs	Providers	Employer & Worker
	Team structures are optimised for performance and autonomy • Team structures are optimised to support Case Managers to enhance performance and autonomy • Foster a culture that encourages CM autonomy according to their capability • Have clear mechanisms for identifying CM proficiency so that decisions can be triaged and assigned based on competence	✓	✓		
	Providers are informed about the Treatment Decision Making Framework • Ensure Treatment Providers are educated in the principles of the Framework • Treatment Provider peak bodies are engaged to support the objectives and outcomes of the Framework	✓ ✓	✓		
D4 – Systems & Processes Decision Makers must know the processes to follow and leverage the Treatment Decision Making Network to obtain the right information, interpret the information and apply it to treatment decisions correctly.	**Escalation pathways for the Treatment Decision-Making Network are clear** • Clearly defined trigger points to indicate internal or external reviews or investigations • Ensure all stakeholders adhere to timeframes within the escalation process • A clear definition of when to escalate to icare	✓	✓		

Domains of Focus (continued)

Domain	Outcome	icare	CSPs	Providers	Employer & Worker
	Improved transparency of decision rationale • Ensure all stakeholders in the Decision-Making Network can access the decision rationale and it is clearly understood	✓	✓		
	Optimised processes for the collation of information to support sound decisions • Enable mechanisms such that sufficient evidence supporting a treatment request is available at the earliest opportunity • Improve alignment on sufficient evidence required to determine reasonably necessary	✓	✓		
	Continuous improvement and innovation based on performance insights • Leverage performance insights to inform the continuous improvement of treatment decision-making processes	✓	✓		
	Effective Change Management that can operationalise changes in legislation	✓	✓		
	Systems enable efficient treatment decision making and augment Case Manager capability • Ensure systems (case management systems, knowledge article repositories, etc) are designed to support the decision maker by streamlining workflows, reducing the opportunity for human error, and by assisting the Case Manager in their activities and decisions • Ensure System fixes and improvements are expedited and consider downstream impacts • Improve the usability of systems and tools	✓	✓		

Domains of Focus (continued)

Domain	Outcome	icare	CSPs	Providers	Employer & Worker
D5 – Performance Measures Decision Makers require defined metrics of success and timely feedback to ensure consistent quality of decisions and reporting. Measures should be reinforced contractually.	**Accessible and effective metrics that account for decision quality** • Establish and agree on success measures for claims, CSPs and the NI and TMF schemes • Establish and agree on outcome-based performance metrics • Ensure metrics are readily accessible to the Decision-Making Network	✓	✓		
	There is accountability at all levels for performance • Each level in the scheme (Claims Management, CSP, icare) are held accountable for their performance • Each level in the scheme is accountable for the tracking and reporting of performance metrics • Key Result Areas (KRAs) reflect the important performance metrics	✓	✓		
	There are mechanisms for monitoring risk and trends • Enable mechanisms for measures & insights to be regularly shared (at each level) to inform and enhance performance • Enable mechanisms to identify trends, performance, and risk factors to solve scheme-wide issues	✓	✓		

3. The Framework on a Page

Claims frontline staff making treatment decisions that are outcome focussed, consistent and compliant				
Case Managers can interpret legislative requirements and have sufficient time to work within the compliance timeframes to manage the nuances and complexity of treatment decision making effectively	Case Managers are empowered to assess requests confidently and know how to leverage support teams to determine 'reasonably necessary' and make soundly based, outcome focused decisions	Case Managers can gather and interpret the right information to consider the worker's holistic needs and make well supported decisions	Case Managers can use the systems and tools to easily and reliably enhance decision making capability, and enable the transparency of decision rationale	Case Managers understand the quality metrics and act upon timely insights to ensure consistent quality of decisions

Domains of Focus and Target Outcomes				
Governance	**People & Accountability**	**Professional Standards & Capability**	**Systems & Process**	**Performance Measures**
• Clear understanding of the 'reasonably necessary' criteria across the Decision-Making Network • Compliance timeframes are met • Treatment Decisions must be outcome-focussed • Embedding evidence-based clinical practice to maximise recovery	• Clear understanding of the roles and accountabilities of the Decision-Making Network	• Case Managers are empowered to confidently assess and make soundly based, outcome focussed decisions • Team structures are optimised for performance and autonomy • Providers are informed about the Treatment Decision Making Framework	• Escalation pathways for the Treatment Decision Making Network are clear • Improved transparency of decision rational • Optimised processes for the collation of information to support sound decisions • Continuous improvement and innovation based on performance insights • Effective change management to reflect changes to legislation • Systems enable efficient treatment decision making and augment Case Manager capability	• Accessible and effective metrics that measure decision quality • There is accountability at all levels for performance • There are mechanisms for monitoring for risk and trends

4. Glossary of Terms

Category	Term	Description
Organisation	AP	Authorised Provider (Allianz, GIO and QBE)
	CSP	Claims Service Provider
	ICOT	icare Claims Operation Team
	IP	Improvement Program
	IRO	Independent Review Office
	MSP	Medical Support Panel
	NI	Nominal Insurer
	PIEF	Personal Injury Education Foundation
	TMF	Treasury Managed Fund
	SIRA	State Insurance Regulatory Authority
Process	AHRR	Allied Health Recovery Request
	CCD	Continuous Claims Delivery
	CoC	Certificate of Capacity
	IMP	Injury Management Plan
	QA	Quality Assurance
	RTW	Return to Work
Role	AH	Allied Health
	CM / CMS / CA	Case Manager / Claim Management Specialist / Claim Advisor
	CX	Customer Experience
	GP	General Practitioner
	GP	General Practitioner

Glossary of Terms (continued)

Category	Term	Description
Role (continued)	IC	Independent Consultant
	IMC	Injury Management Consultant
	IME	Independent Medical Examiner/Examination
	IMS / IMA	Injury Management Specialist / Injury Management Advisor
	Leadership Triangle	Consists of the Injury Management Specialist, Technical Specialist and Team Lead. Also known as the 'Diamond'.
	NTD	Nominated Treating Doctor (usually a GP)
	NTS	Nominated Treating Specialist
	TL	Team Lead - Part of the Leadership Triangle for Case Managers
	Treatment Decision Making Network	See 2.2 -- the stakeholders that play a role in Treatment Decisions
	TS	Technical Specialist - Part of the Leadership Triangle for Case Managers
	WRP	Workplace Rehabilitation Provider
System	CRM	Customer Relationship Management platform in Salesforce
	GWCC	Guidewire Claims Centre (claim management system)
	ODG	Official Disability Guidelines
Term	BAU	Business as Usual
	KA	Knowledge article
	KPI	Key Performance Indicator
	RN	Reasonably Necessary
	TDMF	Treatment Decision Making Framework
	VBC	Value Based Care
	KRA	Key Result Area

Appendix A: SIRA: 4.2 Determining reasonably necessary treatment

4.2 Determining reasonably necessary treatment

Before approving or paying for a medical, hospital or rehabilitation treatment or service, an insurer will determine, based on the facts of each case, whether the treatment or service is, as a result of an injury, reasonably necessary.

Section 60(2C)(a) of the 1987 Act allows for the Guidelines to set rules for determining whether medical or related treatment, as defined by section 59 of the 1987 Act, is reasonably necessary.

When considering the facts of the case, the insurer is to understand that:

- what is determined as reasonably necessary for one worker may not be reasonably necessary for another worker with a similar injury
- reasonably necessary does not mean absolutely necessary
- although evidence may show that a similar outcome could be achieved by an alternative treatment, it does not mean that the treatment recommended is not reasonably necessary.

In most cases, the points above should be enough for an insurer to determine what is reasonably necessary treatment.

If the insurer remains unclear on whether a treatment is reasonably necessary, then the following factors may be considered:

- the appropriateness of the particular treatment
- the availability of alternative treatment
- the cost of the treatment
- the actual or potential effectiveness of the treatment
- the acceptance of the treatment by medical experts.

Workers compensation guidelines | SIRA: Workers compensation claims management guide (nsw.gov.au)

Appendix B: Clinical Framework

SIRA expects that "As a health professional you should apply the nationally endorsed clinical framework for the delivery of health services when treating people injured in motor vehicle accidents or workplace incidents."

The Purpose, Principles and Expectations of the Clinical Framework are shown below. The Clinical Framework document can be found on SIRA's website here.

https://www.sira.nsw.gov.au/resources-library/motor-accident-resources/publications/for-professionals/clinical-framework-single.pdf

Purpose

The Clinical Framework has been established to:

- optimise participation at home, work and in the community, and to achieve the best possible health outcomes for injured people
- inform healthcare professionals of our expectations for the management of injured people
- provide a set of guiding principles for the provision of healthcare services for injured people, healthcare professionals and decision makers
- ensure the provision of healthcare services that are goal orientated, evidence based and clinically justified
- assist in the resolution of disputes

Principles

The Clinical Framework is a set of principles for the provision of health services to injured people.

- Measure and demonstrate the effectiveness of treatment
- Adopt a biopsychosocial approach
- Empower the injured person to manage their injury
- Implement goals focussed on optimising function, participation and return to work
- Base treatment on the best available research evidence

Expectations

All healthcare professionals providing services to injured people as part of transport accident or workers compensation schemes are expected to adopt these principles within the standards and boundaries of their professional expertise. The principles apply to all compensable injuries regardless of their severity. Healthcare professionals are also expected to adhere to documentation and record keeping standards as required by their relevant professional body.

Appendix C: Professional Standards Framework Core Competencies

Our core competencies

The Professional Standards will be achieved through meeting our Core Competencies.

Positive Connections	Effective Communication	Empowering Customers	Engagement and Collaboration	Conflict Resolution	Ethical Conduct
Empowered Leadership	Coaching	Driving Performance	Managing Change		
Holistic Case Management	Medical Management	Injury Management Planning	Return to Work Planning	Strategic Thinking and Risk Analysis	
Scheme Regulation	Legislation and Compliance	Eligibility and Liability	Weekly Benefits and Entitlements	Documentation and Records Management	
Bringing Best Self	Manage Self	Sound Judgement	Accountability	Diversity and Inclusion	
Business Enablers	Financial Acumen	Digital LIteracy	Portfolio Management		

Disclaimer

This document contains general information to stakeholders within the workers compensation scheme in NSW. This document does not constitute legal advice, and to ensure you comply with your legal obligations you must refer to the appropriate legislation as currently in force.

While reasonable care is taken to keep the content of this document up to date, icare makes no warranties about its accuracy, currency or suitability for any particular purpose.

icare™
Insurance and Care NSW

Professional Standards Framework
NSW Nominal Insurer & Treasury Managed Fund Workers Compensation

December 2021

Contents

About icare

Who are we

We provide insurance and care to the people, businesses and communities of NSW. We act for, administer and provide services to a range of government insurance and care schemes, including Workers Insurance, Insurance for NSW, Lifetime Care and Support, Dust Diseases Care, Home Building Compensation and Sporting Injuries.

What we do

- We insure over 310,000 public and private sector employers in NSW and their 4 million employees.
- We support over 1,300 people who have been severely injured on NSW roads.
- Our Dust Disease Care Scheme provides comprehensive medical care and financial assistance for 4,500 people affected by work-related dust diseases.
- We insure nearly 17 billion dollars' worth of building and renovation works annually.
- We help protect and insure the states' most important assets such as our schools and hospitals along with the Sydney Harbour Bridge and the Opera House.
- We provide sporting injuries insurance and care services for 125 sports organisations across NSW.

How we do it

We partner with our Claims Service Providers to ensure a high standard of service is provided to workers and employers. The icare Professional Standards Framework reflects our joint commitment to ensure NSW workers and employers have adequate workers' compensation and return to work support.

Introduction to Professional Standards

icare is committed to developing the skills and knowledge of claims management professionals

The Professional Standards Framework for NSW Nominal Insurer and Treasury Managed Fund Workers Compensation sets out the practices, skills, knowledge and behaviours required by our claims management teams on entry to the industry and throughout their career. It has been designed to help guide consistent decision making and provide high standards of service for our workers and employers. Overtime, as our needs evolve, so will the need to enhance and refine our Professional Standards.

It outlines the standards to support building and maintaining competence, promoting career progression and fostering a learning and development culture.

The Professional Standards Framework details the:

- core competencies within each standard,
- proficiency levels for each core competency,
- expected minimum skills and knowledge.

This enables claims management professionals to evaluate the competencies required for their role.

PART A:
PROFESSIONAL STANDARDS FRAMEWORK

Structure of the Professional Standards Framework

Commitments, Standards, Competencies and Proficiencies

The structure of the Professional Standards Framework includes a hierarchy of Commitments, Standards, Competencies and Proficiencies.

There are five (5) **Claims Model Commitments** that overarch the standards to foster consistent behaviour and service delivery.

The six (6) **Professional Standards** outline the practices, skills, knowledge, and behaviours claims management professionals must demonstrate to be successful within Workers Compensation. The standards are achieved through uplifting capability within the **Core Competencies and Proficiencies.**

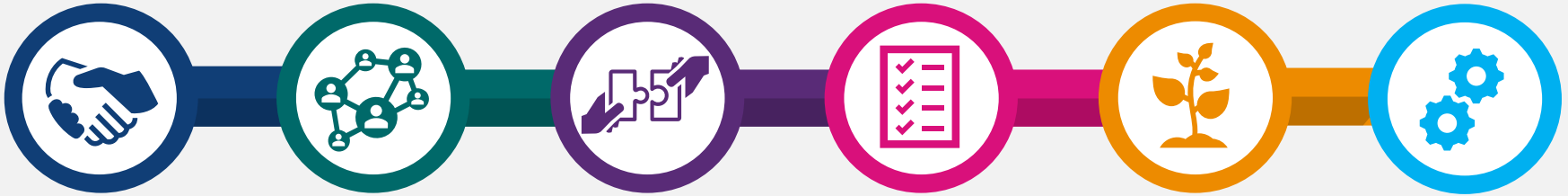
Our Claims Model Commitments

Our five Claims Model Commitments overarch the Professional Standards Framework, to foster consistent behaviour and service delivery. The commitments are anchored to the SIRA Customer Service Conduct Principles and have been designed to guide expectations on the way we service our workers, employers and stakeholders across NSW, and to support return to health and work outcomes.

Guide me	Understand me	Collaborate with me	Help me move forward	Value my time
We enable access & clarity of information for injured workers, employers & relevant parties... so that injured workers & employers can confidently navigate the process.	We understand the holistic needs of injured workers & employers, responding to these consistently & empathetically... so that injured workers & employers feel understood & acknowledged.	We enable transparency & accountability of actions through collaboration... so that all parties are clear about their role & obligations.	We facilitate fair, evidence based decision making... so that injured workers & employers can focus on moving forward.	We continually seek efficiency in our processes & operations to help make the complex simple.... so that injured worker & employer experiences reflect the value we place on their time & resources.
SIRA Customer Service Conduct Principles				
Be accountable for actions & honest in interactions with customers.	Act fairly with empathy & respect.	Resolve customer concerns quickly, respect customers time & be proactive.	Have systems in place to identify & address customer concerns.	Be efficient & easy to engage with.

Our Professional Standards

The Professional Standards encompass the practices, skills, knowledge and behaviours that are critical for claims management teams to promote professional growth and aspiration towards industry best.



Positive Connections

We collaborate and communicate openly to create positive experiences.

Empowered Leadership

We inspire and empower others to maximise potential and achieve common goals.

Holistic Case Management

We take a holistic approach to facilitate recovery and return to work.

Scheme Regulation

We adhere and comply to the NSW workers compensation legislation, regulations, standards and guidelines.

Bringing Best Self

We role model behaviours and mindsets that bring our best self to work, and we support others.

Business Enablers

We apply the right skills, tools and resources to achieve timely and quality outcomes.

Our Core Competencies

The Professional Standards will be achieved through meeting our Core Competencies.

Positive Connections	Effective Communication	Empowering Customers	Engagement and Collaboration	Conflict Resolution	Ethical Conduct
Empowered Leadership	Coaching	Driving Performance	Managing Change		
Holistic Case Management	Medical Management	Injury Management Planning	Return to Work Planning	Strategic Thinking and Risk Analysis	
Scheme Regulation	Legislation and Compliance	Eligibility and Liability	Weekly Benefits and Entitlements	Documentation and Records Management	
Bringing Best Self	Manage Self	Sound Judgement	Accountability	Diversity and Inclusion	
Business Enablers	Financial Acumen	Digital Literacy	Portfolio Management		

Our Proficiency Levels

Each competency is divided into four levels of proficiency, which provides a pathway that progressively increases in complexity. For each level, the knowledge of the lower level(s) is assumed.

Foundational

Applies the fundamentals and understanding of the concepts and competencies in case management.

Identifies when support is required, particularly in regards to complex tasks.

Intermediate

Applies the concepts and competencies in case management for complex situations.

Requires occasional support, particularly in regards to complex tasks.

Advanced

Independently applies the concepts and competencies in case management with ability to influence others.

Supports and guides others.

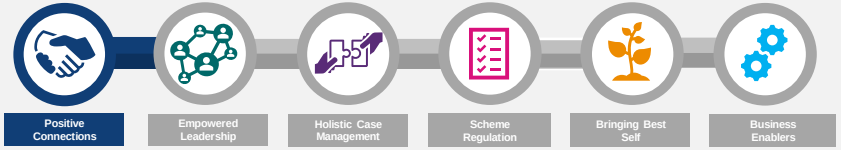
Expert

Applies concepts and ideas to respond to new and emerging situations, understands organisational issues and trends and proactively devises strategies to mitigate impacts to ensure optimal customer and business outcomes are achieved.

Coaches and guides others on the application of all competencies and is recognised as specialist in exercising the competencies.

Makes strategic decisions to support business objectives.

PART B:
DETAILED VIEW OF CORE COMPETENCIES AND PROFICENCIES



Positive Connections

We collaborate and communicate openly to create positive experiences

Core Competencies:

- Effective Communication
- Empowering Customers
- Engagement and Collaboration
- Conflict Resolution
- Ethical Conduct

Effective Communication

Communicates with honesty, openness, and transparency, in both verbal and written forms, to build trusting and empathetic partnerships in a timely manner.

Foundational	Intermediate	Advanced	Expert
Uses proactive, timely and appropriate communication to build rapport and trust with customers. Communicates with empathy, clarity, fairness and transparency, in both written and verbal communication, to build trust and gain commitment to claim goals and actions. Applies active listening, questioning techniques and plain language to ensure clarity and unambiguous delivery and comprehension of information. Understands and provides accessibility services when required.	Adapts communication method and style as necessary to respond to the expectations and needs of different audiences, that's easy to understand. Tailors communication frequency and method when there are changes to the prior communication arrangements. Integrates an understanding of verbal with non-verbal communication skills that positively affects customer relationships.	Approaches complexity with a clear understanding of the impact, key issues and negotiates with influence whilst maintaining rapport and trust. Guides and coaches others on timely communication with consideration to legislative requirements. Evaluates own communication for appropriate language, clarity of information, consistency and compliance.	Guides and coaches others on opportunities to listen to customers and other stakeholders whose input add value. Evaluates own and teams' communication to enhance customer and other stakeholder interactions.

Empowering Customers

Enable workers and employers (customer) to make their own decisions and achieve successful recovery and return to work outcomes, through identification of customer needs and sharing of information, tools and resources.

Foundational	Intermediate	Advanced	Expert
Encourages worker and employer participation and decision making regarding their recovery and return to work.	Provides access to suitable information, tools, resources and services that improves customer decision making to optimise worker recovery and return to work outcomes.	Promotes a worker's health literacy and beliefs in their own abilities, to foster worker independence and empowerment.	Approaches customer interactions with an understanding of workers and employers strengths to optimise the worker's functional and psychosocial independence.

Engagement and Collaboration

Build and manage effective partnerships through education and collaboration, to identify effective solutions and drive better customer outcomes.

Foundational	Intermediate	Advanced	Expert
Understands the role of the worker and employer as the 'customer', and the role of other stakeholders in the workers compensation system to build open partnerships. Understands the benefits of working in consultation and collaboration with customers, and other stakeholders to achieve customer outcomes.	Applies knowledge of customer and other stakeholder roles and expectations to develop open, honest and transparent partnerships. Uses consultation, collaboration and education to generate responses and solutions to meet customer needs.	Anticipates and is responsive to customer and other stakeholder needs and expectations. Fosters teamwork and collaboration to develop customer solutions.	Guides and coaches others on opportunities to engage with customers and other stakeholders, and build positive partnerships. Evaluates the teams' interactions with customers and other stakeholders to drive better claim outcomes in accordance with legislation and guidelines.

Conflict Resolution

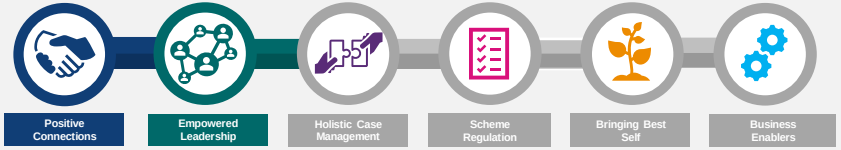
Identify, prevent and resolve conflict in a timely manner to improve customer outcomes and maintain positive working relationships through effective communication.

Foundational	Intermediate	Advanced	Expert
Understands the difference between a complaint, feedback, enquiry, dispute and litigation, and appropriate processes. Understands the impact of own actions on customer relationships and identifies opportunities to improve customer relationships. Applies the technical timescales to managing conflict and informs customers of these. Identifies the internal management, technical and legal bodies that can assist with resolving conflict.	Acknowledges and resolves conflict to reach mutually beneficial solutions. Maintains effective relationships with customers while resolving conflict. Applies correct processes to resolve and/or escalate conflicts in a timely manner to minimise impact on the customer. Prepares objective and concise referral documentation to escalate conflicts to internal teams.	Guides and coaches teams so that they are empowered to resolve customer conflicts within organisational guidelines and standards, whilst maintaining customer-focussed claims management. Proactively seeks customer feedback using various tools and channels, and follows up on this feedback.	Evaluates the conflict resolution processes and outcomes to improve the customer experience in reaching mutually agreeable solutions. Prepares and represents the business with responding to conflicts referred to icare, SIRA or IRO.

Ethical Conduct

Act with integrity and apply ethical decision making to protect workers.

Foundational	Intermediate	Advanced	Expert
Understands and identifies factors that impact on ethical decision-making. Identifies when ethical issues may arise, and develops strategies for dealing with possible scenarios.	Applies ethical decision making to comply with organisational policy, procedure, SIRA principles of practice and relevant legislation. Applies reasonable course of action when confronted with ethical dilemmas, and considers the best interests of all parties.	Promotes ethical decision making with workers, employers, colleagues and other key stakeholders. Identifies risks and impact of ethical scenarios, and takes action to mitigate harm to others. Models high standards of ethical and professional behaviour and reinforce their use.	Evaluates the outcome of ethical decision making to determine consequences for the team, affected parties and the organisation. Evaluates outcome of responses to ethical situations for the team and affected parties, to guide appropriate courses of action to resolve future issues. Considers the common good of the community being served.



Empowered Leadership

We inspire and empower others to maximise potential and achieve common goals

Core Competencies:

- Coaching
- Driving Performance
- Managing Change

Coaching

Motivates self and others to set goals, develop capability and achieve performance outcomes through influence, feedback and coaching.

Foundational	Intermediate	Advanced	Expert
Offers support, provides constructive feedback and drives knowledge exchange with a coaching mindset.	Understands effective coaching techniques. Develops self and guides others using active listening, effective questioning, solution focus and ability to overcome barriers. Overcomes objections and improves self-awareness of what works and what doesn't.	Applies effective coaching techniques to develop others. Establishes trusting relationships to influence growth and development. Identifies key behaviours and influencing tactics for different audiences to structure and deliver tailored information persuasively to achieve results.	Identifies and develops talent and encourages and motivates people to engage in setting goals, career planning and continuous learning. Builds claims capability and responsiveness by inspiring a culture of coaching and growth.

Driving Performance

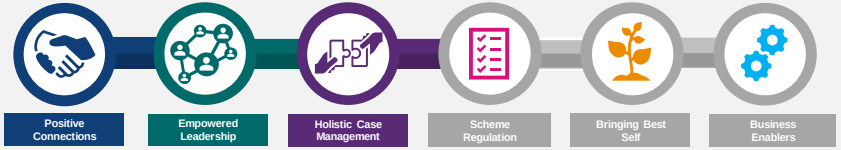
Builds the skills and tools to think more like a leader of the business and to understand, set and execute the right strategies to drive continuous improvement, outcomes and performance.

Foundational	Intermediate	Advanced	Expert
Understands and adheres to the key performance indicators to drive scheme outcomes. Understands and identifies opportunities for continuous improvement. Understands the fundamentals of team resource management and work allocation.	Understands performance drivers and how they contribute to positive outcomes. Identifies and effectively plans how best to drive continuous improvement. Understands how to use the skills and experience of others to deliver customer, team and business objectives.	Supports teams to identify connections between performance, goals and organisational objectives. Drives and executes improvement plans for the team. Develops, implements and monitors appropriate team resourcing and work allocation according to need.	Sets team direction, goals and objectives through inspiring purpose. Creates a culture that seeks opportunities for continuous improvement and better performance outcomes for the scheme. Manages workforce planning and operational priorities to ensure the appropriate allocation of time and other resources to achieve high quality outcomes.

Managing Change

Ability to lead, assess, prepare and support the implementation of sustainable change by effectively managing impact and resistance.

Foundational	Intermediate	Advanced	Expert
Recognises and understands the constant nature and need for operational change. Identifies potential impacts of change and adapts by remaining flexible.	Deals with uncertainty and supports others in understanding the impacts of change, and connection to business objectives. Early adopter of change and assists others throughout the change management cycle.	Secures commitment to change and engages in effective communication during the change process. Analyses change, determines impacts and manages resistance through mitigation techniques. Champions a culture of change to ensure ongoing embedment and reinforcement.	Defines high level objectives to drive a change agenda, and translates into practical implementation strategies. Implements operational change, aligned to business objectives. Fosters a culture of change to ensure ongoing embedment and reinforcement.



Holistic Case Management

We take a holistic approach to facilitate recovery and return to work

Core Competencies:

- Medical Management
- Injury Management Planning
- Return to Work Planning
- Strategic Thinking and Risk Analysis

Medical Management

Interpret medical information, to make timely decisions on evidence-based treatment, facilitate recovery/return to work, and identify when to seek technical support and specialised information.

Foundational	Intermediate	Advanced	Expert
Understands and demonstrates knowledge of medical conditions common in workers compensation, functional impacts, symptoms and prognosis to facilitate recovery/return to work. Determines timely requests for evidence-based treatment in line with legislative requirements, SIRA Guidelines and Standards of Practice. Seeks technical support, specialist information and guidance when required.	Applies knowledge of medical conditions, functional impacts, symptoms and prognosis, to facilitate recovery/return to work. Applies knowledge of evidence-based treatment to make timely decisions on requests for treatment approval.	Analyses the difference between symptoms, functional impacts and work disability to determine implications for workers' recovery/return to work. Analyses the effectiveness of treatment in supporting customer empowerment on their recovery/return to work outcomes. Assesses the reasonableness of treatment requests for complex medical conditions, experimental treatment and surgery requests. Explores recovery and return to work options with treating professionals.	Evaluates inconsistencies and gaps in relation to medical conditions, functional impacts, symptoms and prognosis to influence recovery/return to work solutions consistent with evidence-based practice. Guides and coaches others on evaluating and managing treatment requests and medical costs.

Injury Management Planning

Ability to utilise injury management planning as a collaborative and empowering communication tool, to facilitate positive and sustainable recovery and return to work outcomes.

Foundational	Intermediate	Advanced	Expert
Develops timely, customer-centric Injury Management Plans, with recent engagement from relevant stakeholders.	Negotiates timely, customer-centric Injury Management Plans with relevant stakeholders, to facilitate recovery/return to work outcomes.	Analyses the impact of collaborative, timely and quality Injury Management Plans on recovery/return to work outcomes and worker empowerment.	Guides and coaches others on the development of quality and timely Injury Management Plans, and the impact on stakeholders in relation to empowerment, recovery and return to work.

Return to Work Planning

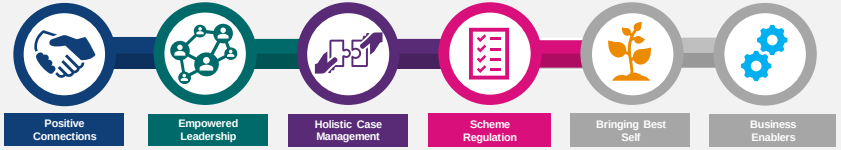
Understand the principles of the Health Benefits of Good Work and early intervention, to educate and facilitate suitable and sustainable return to work outcomes.

Foundational	Intermediate	Advanced	Expert
Understands and applies the concepts of the Health Benefits of Good Work, early intervention and recovery at work to support suitable return to work. Identifies opportunities for suitable return to work. Seeks workplace rehabilitation support, specialist information or guidance when required.	Educates stakeholders on the Health Benefits of Good Work, early intervention and recovery at work philosophies, to facilitate engagement and worker empowerment to return to work. Facilitates suitable return to work, seeking workplace rehabilitation support to achieve clear, agreed return to work goals when required.	Applies the principles of the Health Benefits of Good Work, early intervention and recovery at work to facilitate worker and employer engagement to achieve suitable return to work on complex claims. Analyses and assesses the efficacy of workplace rehabilitation services to achieve value-based return to work outcomes.	Promotes and educates internal and external stakeholders on the Health Benefits of Good Work, early intervention and recovery at work, to cultivate a return to work focus. Creates and innovates return to work strategies utilising workplace rehabilitation to achieve return to work outcomes on complex claims.

Strategic Thinking and Risk Analysis

Develop an appropriate claims management strategy that routinely recognises bio-psychosocial factors and risks, to determine customer needs and ensure workers are aligned with appropriate services.

Foundational	Intermediate	Advanced	Expert
Identifies bio-psychosocial factors and risks to proactively develop, revise and implement strategies to achieve recovery/return to work goals. Understands the concept and purpose of initial and on-going claims triage. Seeks technical support, information and guidance when required.	Interprets complex bio-psychosocial factors and risks that impact recovery/return to work goals, to develop, revise and implement appropriate claims strategies. Determines the factors and variables that influence identification of risk factors during initial and on-going triage, to confirm the claim is aligned with the right service.	Evaluates the interplay of complex claim and bio-psychosocial factors to mitigate barriers which adversely affect recovery/return to work goals. Anticipates worker outcomes based on the initial and on-going triage of claims, and re-aligns claims to more appropriate services when required. Anticipates risk to recovery and return to work to develop and implement mitigation strategies.	Guides and coaches others on analysing claim and bio-psychosocial factors to develop effective strategies for positive recovery/return to work goals. Guides and coaches others on triaging approach, to align customer needs with the appropriate support and services, and improve the effectiveness of claims management.



Scheme Regulation

We adhere and comply to the NSW workers compensation legislation, regulations, standards and guidelines

Core Competencies:

- Legislation and Compliance
- Eligibility and Liability
- Weekly Benefits and Entitlements
- Documentation and Records Management

Legislation and Compliance

Knowledge of legislation within NSW Workers Compensation, administrative law, and the compliance requirements established by icare, SIRA and the Claims Service Provider. *Note: Reference to workers compensation acts below include the Workers Compensation Act 1987, Workplace Injury Management and Workers Compensation Act 1998 and Workers' Compensation Act 1926.*

Foundational	Intermediate	Advanced	Expert
Identifies and applies the correct workers compensation acts and complies to and within delegated authority. Identifies and applies other legislation, compliance and SIRA standards of practice relevant to claims management, including obtaining and sharing of information under privacy, administrative law and fraud. Seeks technical support and guidance on legislative and complex matters.	Applies workers compensation legislation and compliance accurately and complies to and within delegated authority. Applies and discusses the correct privacy requirements, administrative law and fraud with stakeholders.	Guides and coaches others and external stakeholders on workers compensation acts, regulatory and compliance issues including compliance with delegated authority. Guides and coaches others and educates external stakeholders on other legislative and compliance technical issues such as privacy, administrative law and fraud.	Understands the impact of new laws or changes to existing legislation/compliance and influences, and contributes to any process changes at an operational level. Analyses data trends regarding breaches to privacy and delegated authority, and coaches and guides team on compliance with procedures when required.

Eligibility and Liability

Knowledge and skills to make decision rights in regards to claim eligibility and enact liability decisions on new, ongoing and recurrent claims, in accordance with relevant policies, workers compensation legislation and industry standards.

Foundational	Intermediate	Advanced	Expert
Applies non-complex medical and factual information to make timely and sound eligibility and liability decisions in accordance with relevant legislation, and understands the impact of decisions on customers, particularly workers with psychological injury.	Interprets complex medical and factual information to make evidence-based, timely and sound eligibility and liability decisions in accordance with relevant legislation.	Guides and coaches others on gaps and inconsistencies in information to enable evidence-based, timely and sound eligibility and liability decisions in accordance with relevant legislation.	Evaluates eligibility and liability decisions to ensure timely and accurate evidence-based and sound decisions have been determined, including implications on customers, the organisation and scheme. Guides and coaches others on complex application of case law with regards to eligibility and liability.

Weekly Benefits and Entitlements

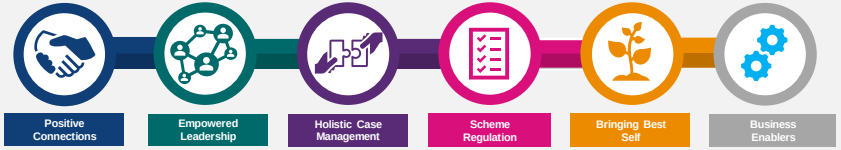
Understanding of how weekly benefits, Work Capacity Decisions and other payments and entitlements are calculated within NSW Workers Compensation.

Foundational	Intermediate	Advanced	Expert
Obtains the information required to determine weekly benefits (e.g. Pre-Injury Average Weekly Earnings (PIAWE), Average Weekly Earnings (AWE), Current Weekly Wage Rate (CWWR), Work Capacity Decisions). Applies the appropriate approach to make accurate and timely payments. Understands the relevant legislation and SIRA Guidelines that relate to permanent impairment entitlements. Seeks technical support and guidance when required.	Calculates weekly benefit (PIAWE, AWE, CWWR, Work Capacity Decisions) in line with legislative requirements, SIRA Guidelines, Standards of Practice and organisational procedures, on complex claims. Applies the appropriate legislation to make accurate and timely payments independently. Applies the relevant legislation and SIRA Guidelines to assess and calculate non-complex permanent impairment entitlements, and other benefits throughout the life cycle of a claim.	Reviews and approves complex weekly benefit calculations (PIAWE, AWE, CWWR, Work Capacity decisions) that include multiple components. Supports others to identify and assess other entitlements under the relevant workers compensation acts, within SIRA and organisational guidelines and standards. Assesses and calculates timely and accurate permanent impairment and other entitlements in line with legislative requirements, SIRA Guidelines and organisational procedures, on complex claims.	Guides and coaches others to ensure compliance with legislation and regulation requirements regarding assessment and calculation of weekly benefits (PIAWE, AWE, CWWR, Work Capacity decisions). Guides and coaches others to ensure compliance with processes and procedures to assess and calculate other worker entitlements.

Documentation and Records Management

Record, maintain and update information and communications which are timely, objective, accurate and succinct to ensure data integrity.

Foundational	Intermediate	Advanced	Expert
Records and distributes claims information in accordance with organisational and legislative requirements. Documents appropriate goals and timeframes clearly and succinctly in line with compliance requirements. Records relevant, objective and concise file notes on claims that are easily understood by others. Adheres to privacy and consent obligations. Uses relevant systems to keep information and claim data accurate and up to date.	Records evidence-based reasoning to support goals and timeframes. Understands the implications of maintaining the confidentiality, accuracy and security of information and data fields, including prompt update of information/data as worker circumstances change.	Guides and coaches others on documentation guidelines and implications for not keeping accurate and complete records. Interprets, analyses and records relevant claims data and identifies strategies to manage in a range of complex and/or unfamiliar situations.	Evaluates compliance with documentation and privacy principles, and influences the amendment of processes and procedures where required. Guides and coaches others to document clear, objective and succinct notes and information. Evaluates the impact of poor data integrity on the team compliance and influences amendment of processes and procedures where required.



Bringing Best Self

We role model behaviours and mindsets that bring our best self to work, and we support others

Core Competencies:

- Manage Self
- Sound Judgement
- Accountability
- Diversity and Inclusion

Manage Self

Develops a growth mindset and resilience by embracing challenges as opportunities, demonstrating initiative and perseverance.

Foundational	Intermediate	Advanced	Expert
Shows drive and motivation with a commitment to personal development and continuous learning. Recognises barriers and obstacles, and displays persistence to adapt to new situations. Embraces innovation and change. Seeks support with confidence and embraces challenges as opportunities for growth.	Reflects on own development, proactively seeks feedback and works with leader/manager to identify development opportunities. Monitors own emotional reactions and responses, displays positive outlook in challenging situations and responds in a flexible, positive manner to change. Demonstrates initiative to identify solutions and overcome barriers.	Actively seeks, reflects and acts on feedback on own performance for growth and development. Remains positive and responds to pressure in a calm manner. Able to recover from setbacks and find alternate solutions. Displays flexibility and adaptability.	Actively seeks, reflects on and integrates feedback to enhance own performance, showing a strong capacity and willingness to modify own behaviour for growth. Uses a range of strategies to remain composed and calm and act as a stabilising influence on colleagues. Demonstrates initiative to achieve objectives even in difficult circumstances.

Sound Judgement

Evaluating situations or circumstances with objectivity, fairness and reason to form considered decisions.

Foundational	Intermediate	Advanced	Expert
Displays objectivity and is able to act with fairness and reason.	Considers the implications of making a decision and weighs options to identify a solution. Understands the principles of treating customers fairly to support a culture of honesty and fairness. Applies fair review of customer needs and balances different perspectives in decision making.	Undertakes objective and systematic analysis to form conclusions based on evidence, and is aware of assumptions and unconscious bias when weighing options to make sound decisions under pressure. Ensures that others are aware of and understand the legislation and policy framework within which they operate. Guides and coaches others on the principles of treating the customers fairly including procedural fairness.	Engages in critical thinking to identify issues, the implications of decision making and develop sound solutions. Drives a culture of fairness, transparency and professionalism. Provides input on policies, procedures and governance frameworks that align with the principles of treating the customer fairly within the team.

Accountability

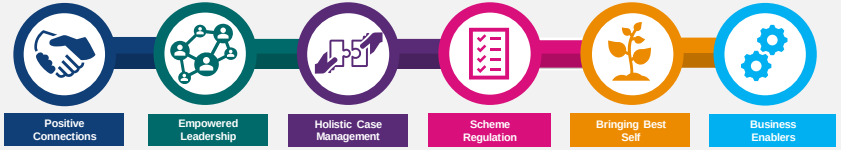
Taking responsibility of one's actions and the duties required of their role by being accountable, responsible and responsive.

Foundational	Intermediate	Advanced	Expert
Acknowledges when they have done well and when they have made mistakes, and seeks guidance and support when required. Actively listens when own ideas are being challenged. Implements actions within agreed timeframes. Takes responsibility for managing work to achieve results.	Acknowledges when they have done well and when they have made mistakes, learns from them, and seeks guidance and support when required. Recognises the impact of one's behaviour on others.	Acknowledges own mistakes and ensures corrective action is taken. Guides and supports others to establish clear responsibilities for monitoring work and results. Follows through with commitments and encourages others to do the same.	Accepts accountability for mistakes made within the team and ensures corrective action is taken. Accepts responsibility for team tasks and actions completed within required timeframes.

Diversity and Inclusion

Behaving in a manner that makes customers and others feel comfortable, respected and valued.

Foundational	Intermediate	Advanced	Expert
Shows respect for diverse backgrounds, experiences and perspectives.	Uses language and concepts appropriate to social, economic, cultural, gender and physical differences. Open to diverse thinking, opinions and ideas of others.	Role models inclusive behaviour. Promotes diverse thinking, opinions and ideas of others. Promotes a customer-focused culture that considers the diversity of customers.	Encourages inclusive behaviour by promoting a culture of diversity. Creates an open environment that welcomes diverse thinking, opinions and ideas of others.



Business Enablers

We apply the right skills, tools and resources to achieve timely and quality outcomes

Core Competencies:

- Financial Acumen
- Digital Literacy
- Portfolio Management

Financial Acumen

Understanding of financial requirements and cost drivers of NSW Workers Compensation to support scheme sustainability.

Foundational	Intermediate	Advanced	Expert
Understands the claim costs and risk factors that impact employer premiums. Recognises the different types of recoveries and notifies appropriate stakeholders when there is a potential recovery on a claim. Understands the relevant guidelines, regulations and gazetted payment rates to approve third party invoices on non-complex claims in a timely basis.	Understands the claim costs and risk factors that impact employer premiums and implications on scheme sustainability. Identifies claims with recovery opportunities and applies timely action to recover monies. Applies knowledge of third party invoices to approve accurate and timely payments on complex invoices independently.	Analyses claims with recovery opportunities and applies timely action to recover monies on complex claims. Advises the team on how to negotiate a solution and/or resolves complex or sensitive issues related to third party approvals.	Understands actuarial metrics, processes and drivers of performance to evaluate and identify opportunities to improve scheme sustainability. Coaches and educates internal and external key stakeholders on scheme cost drivers. Coaches others on recovery opportunities and timeliness of actioning recovery processes. Appraises third party payment approvals to ensure they are within gazetted fees and comply with Australian Taxation laws.

Digital Literacy

Uses information in multiple formats and from a range of sources to obtain, manage, create and communicate data, information and ideas for effective claims management.

Foundational	Intermediate	Advanced	Expert
Demonstrates initiative to understand and use various systems and platforms to access data, information and content in digital platforms. Understands and applies common, various types of communication and collaboration strategies, tools and digital formats.	Compares the credibility and reliability of sources of data, information and digital content. Uses and adapts to new and unfamiliar systems and platforms to communicate and collaborate.	Applies troubleshooting solutions to recurring digital technology problems to access data, information and digital content. Uses systems and platforms to enhance communication and collaboration for self and peers.	Evaluates and analyses the credibility and reliability of data, information and digital content used in information sharing and reporting. Coaches and guides others on different ways to connect and collaborate using systems and platforms.

Portfolio Management

Prioritise, plan and manage workload, and ensure the appropriate allocation of time and other resources to achieve high quality outcomes.

Foundational	Intermediate	Advanced	Expert
Plans, prioritises and organises own time and work to meet business requirements, targets and timeframes with an expected workload, and communicates to those affected if plans cannot be met. Able to utilise tools and techniques to plan and organise time and work more effectively. Identifies when urgent action is required to resolve critical issues.	Plans, prioritises and organises own time and work to meet business requirements, targets and timeframes with relatively higher than expected workload, and communicates to those affected if plans cannot be met. Reviews existing ways of planning and prioritising work to find more efficient ways of working. Initiates appropriate urgent action to resolve issues when required.	Makes decisions and prioritises work demands taking into account and balancing the impacts on the business, customer expectations, regulatory requirements and commercial considerations. Re-prioritises and organises workload to balance urgent and unexpected events with day to day work tasks. Guides others to take appropriate urgent action to resolve issues.	Provides vision and direction in planning, prioritising and organising work and resources at a team level. Anticipates, evaluates and develops plans to deal with unexpected contingencies which may impact on the achievement of team objectives. Displays flexibility and adaptability to accommodate the changing work demands of the team.

icare™

Insurance and Care NSW

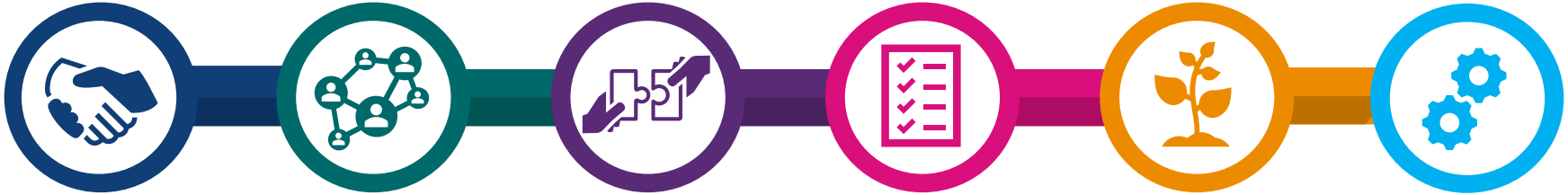
Professional Standards Framework

NSW Nominal Insurer & Treasury Managed Fund Workers Compensation

December 2021 V.1.2

Guide me	Understand me	Collaborate with me	Help me move forward	Value my time

SIRA Customer Service Conduct Principles



Positive Connections	Empowered Leadership	Holistic Case Management	Scheme Regulation	Bringing Best Self	Business Enablers

Achieved through our Core Competencies and Proficiencies

Schedule 2 Remuneration

Note: Schedule 2 and Attachments 2.01 to 2.04 are commercial-in-confidence and not included in this copy for disclosure under Part 3 Div 5 of the *Government Information (Public Access) Act 2009*.

Schedule 3 Performance Management & Governance

Note: Attachment 3.01 is commercial-in-confidence and not included in this copy for disclosure under Part 3 Div 5 of the *Government Information (Public Access) Act 2009*.

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Schedule 3

Performance Management and Governance

Table of contents

Overview

icare believes that a collaborative approach with the Claims Service Provider in relation to performance management provides the best opportunity for achievement of positive outcomes for the Scheme and customers.

This Schedule details:

(a) how the parties' performance of the Contract will be governed and managed, through collaboration between icare and the Claims Service Provider that provides the necessary oversight to enable the Claims Service Provider to meet its obligations under the Contract; and

(b) the parties' respective obligations dealing specifically with management of the parties' relationship.

Glossary

Except where stated otherwise, capitalised terms used in this Schedule and its Attachments have the meaning set out in the Dictionary. Reference to "customers" in this Schedule refers to Employers and Workers.

1. Relationship Principles

1.1 General

The Claims Service Provider must deliver the Services in a way that:

(a) will meet the needs of customers;

(b) delivers outcomes for the Scheme including those targeted towards the outcomes identified in the Performance Measures as defined in both Schedule 2 ("*Remuneration*") and this Schedule; and

(c) complies with the Contract.

1.2 Partnership Principles

icare wishes to build a strong long-term partnership with the Claims Service Provider. To enable this partnership, icare and the Claims Service Provider will:

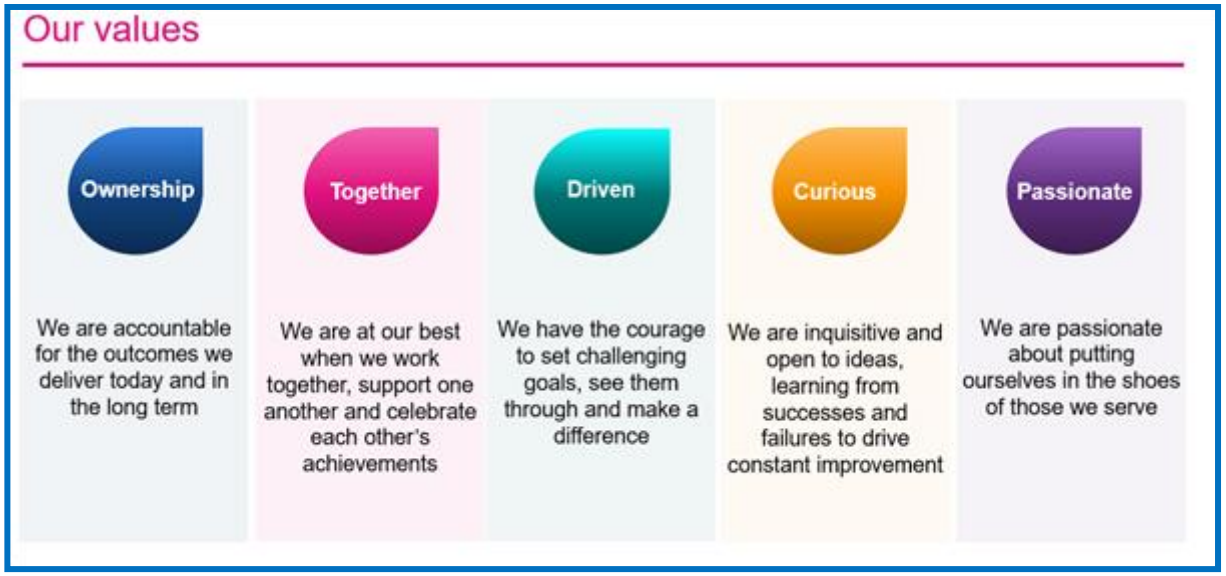
(a) communicate in a manner that is frequent, open and honest and demonstrates mutual respect and trust at all times;

(b) work together to resolve any issues that arise in a timely manner and at appropriate levels of seniority to achieve rapid and durable solutions; and

(c) adopt a shared strategic approach to demonstrate industry leadership and facilitate continuous improvement in achieving the Scheme Outcomes.

1.3 Values

(a) Unless otherwise notified by icare to the Claims Service Provider, icare's core values are:



(b) icare's core values will guide the way icare and the Claims Service Provider work together to manage the Scheme.

(c) icare expects that the Claims Service Provider (including its Personnel) demonstrate and share icare's values when providing Services or performing other obligations under the Contract.

2. Partnership Framework, Personnel and communication

2.1 Partnership Framework

To facilitate the achievement of the Workers Compensation Scheme Principles and the success of the relationship between icare and the Claims Service Provider:

(a) icare's and Claims Service Provider's executives and their Authorised Representatives will provide strategic leadership to achieve the Workers Compensation Scheme Principles and enhance the strategic relationship between the parties;

(b) the icare Authorised Representative and the Claims Service Provider Authorised Representative will oversee relationship management to ensure Services are provided in a way that is consistent with the Workers Compensation Scheme Principles and drives the delivery of strategic initiatives and operational performance and compliance;

(c) the icare Partnering and Performance Manager and the Claims Service Provider Partnering and Performance Manager will drive operational performance and compliance; and

(d) the icare Partnering and Performance Manager and the Claims Service Provider Partnering and Performance Manager will foster a positive and collaborative relationship between icare and the Claims Service Provider and facilitate communication between icare and the Claims Service Provider.

2.2 Key Personnel

(a) **Authorised Representatives**

(i) The Authorised Representatives of icare and the Claims Service Provider are the most senior management team members holding direct accountability for delivery of the Services for their respective organisations.

(ii) The Authorised Representatives or their delegates are responsible for:

(A) managing the strategic relationship of the parties and providing senior leadership and guidance;

(B) ensuring that the Claims Service Provider performs its obligations and acts in all respects in a way that is consistent with, and facilitates the achievement of, the Workers Compensation Scheme Principles;

(C) ensuring their respective organisations fulfil their obligations throughout the Term;

(D) progressing the goals and objectives of the relationship within the scope of the Contract; and

(E) agreeing any Statements of Work or Project Services to be provided under a Delivery Proposal.

(iii) The Claims Service Provider Authorised Representative will be accountable for the Claims Service Provider's performance under this Contract, including against the Performance Measures.

(iv) Without limiting the authority of the icare Authorised Representative, the icare Authorised Representative or their delegate has authority to:

(A) Approve the ratification of any act or omission under clause 8.4 of the Contract Terms;

(B) issue Directions under clause 39 of the Contract Terms;

(C) endorse a Project Services Request signifying icare's authority to commence the process under clause 11 of the Contract Terms and Schedule 4 ("*Project Services Framework*");

(D) sign a Statement of Work;

(E) Approve a Delivery Proposal; and

(F) Approve performance management activities associated with any area of focus detailed in the Performance Management Register (**PMR**), including items recorded in the PMR relating to performance levels achieved by the Claims Service Provider in relation to Outcome Measures, Quality Measures and Operational Measures.

(v) The Claims Service Provider Authorised Representative may delegate their authority on a needs basis, provided that:

(A) they provide the icare Authorised Representative with prior written notice of any such delegation; and

(B) the icare Authorised Representative Approves the delegation.

(b) **Partnering and Performance Managers**

(i) The Partnering and Performance Managers act on behalf of the Authorised Representatives and are responsible for:

(A) providing oversight of Claims performance and compliance, which includes:

(1) monitoring the Claims Service Provider's performance and driving performance with the Claims Service Provider; and

(2) ensuring relevant focus areas (including in respect of performance levels achieved by the Claims Service Provider in relation to Performance Measures) are considered for inclusion in the PMR;

(B) approving and managing the performance management activities on the PMR, in accordance with the delegated authority from the icare Authorised Representative;

(C) contributing to and overseeing the joint initiatives to improve Claims performance and compliance, as detailed in the Claims Service Provider's Annual Business Plan;

(D) supporting the Authorised Representative; and

(E) overseeing and managing the commercial and contractual relationship between icare and the Claims Service Provider, including by:

(1) ensuring clear communications between icare and the Claims Service Provider;

(2) fostering a positive and collaborative relationship between icare and the Claims Service Provider;

(3) solving problems (including problems raised with them by the Partnering and Performance Managers) and escalating problems as required; and

(4) ensuring the Claims Service Provider engages in continuous improvement and innovation, as appropriate.

(ii) The Partnering and Performance Managers must raise any matters requiring escalation with each other in the first instance.

2.3 Communication

(a) **icare and Claims Service Provider**

(i) **Overview**

The parties acknowledge and agree that:

(A) they will manage Contract Disputes in accordance with clause 57 (Contract Disputes) of the Contract Terms;

(B) sections 2.3(a)(ii) and 2.3(a)(iii) below apply to operational and other day-to-day communications between the parties; and

(C) where Directions, changes, requests or escalation may be required over and above day-to-day operational management, the parties acknowledge that these matters should be raised by their Personnel with the icare Partnering and Performance Manager and the Claims Service Provider Partnering and Performance Manager or their delegate in the first instance as appropriate, having regard to the role and functions of the Partnering and Performance Manager.

(ii) **Communication protocol between the parties**

(A) In addition to engagement through meetings and projects, Personnel from icare and the Claims Service Provider will regularly engage on day-to-day operational matters to support the delivery of Services to customers as agreed between the parties.

(B) The parties will issue operational and other day-to-day communications through email correspondence (to and from agreed designated email addresses), meetings and direct engagement between icare and Claims Service Provider Personnel as agreed.

(iii) **Timeframes for communication**

(A) The Claims Service Provider must have a point of contact available at all times to respond to queries from icare and must provide icare with up-to-date contact information, including out of hours contact numbers. icare will issue the majority of queries during normal office hours, however it may issue requests for information outside normal office hours from time to time, including during the weekend.

(B) The Claims Service Provider must respond to requests for information issued by icare within the timeframe specified by icare, unless otherwise agreed. icare may require the Claims Service Provider to respond to requests for information within one hour in response to media and other urgent enquiries.

(C) icare will provide timely responses in relation to operational and other day-to-day enquiries, requests and communications from the Claims Service Provider.

(b) **Claims Service Provider and external parties**

(i) **Communication protocol with SIRA, IRO and NSW Government Agencies**

(A) In respect of any dealings with any Government Agency, including SIRA and the IRO:

(1) the Claims Service Provider must promptly notify icare if it receives a direct request from any Government Agency with respect to the Services; and

(2) the Claims Service Provider will engage in an open, constructive and accountable manner; and

(3) otherwise comply with clause 46.18 of the Contract Terms in respect of any dealings with SIRA.

(B) The Claims Service Provider acknowledges that any recommendations or findings from SIRA or the IRO may be incorporated into a Performance Measure, or introduced as a new Performance Measure, in accordance with Schedule 2 ("*Remuneration*") and this Schedule.

(ii) **Timeframes for communication**

(A) If a Government Agency sets a timeframe for a response from the Claims Service Provider, communicated either directly to the Claims Service Provider or through icare, the Claims Service Provider must use all reasonable endeavours to meet that timeframe without delay.

(B) As soon as the Claims Service provider realises that a regulatory deadline is unlikely to be met, the Claims Service Provider must promptly advise icare, to enable icare to communicate this to the relevant Government Agency.

3. Governance

3.1 Introduction

(a) The Governance Framework is designed to assist the Claims Service Provider to achieve, and to monitor the Claims Service Provider's performance of, the Performance Measures, its Service obligations and compliance requirements under the Contract.

(b) The Governance Framework includes the regular meetings that will be in place between the Claims Service Provider, Other Claims Service Providers and icare. The meetings will provide oversight and will operate as collaborative forums to discuss strategic direction of the relationship, innovation, scheme and portfolio performance, service delivery, compliance and agreed actions required to support achievement of the Workers Compensation Scheme Principles. However, the meetings are not a substitute for, and do not impact, decision-making processes and delegations set out in the Contract.

3.2 Meetings

(a) **Overview of meetings between icare and Claims Service Provider**

(i) icare will establish at a minimum the following meetings with the Claims Service Provider:

(A) Portfolio and Performance Meetings (to be held monthly or as agreed between the icare Partnering and Performance Manager and the Claims Service Provider Partnering and Performance Manager);

(B) Strategic Leadership Meetings (to be held Quarterly or as agreed between the icare Authorised Representative and the Claims Service Provider Authorised Representative);

(C) Scheme-Wide Performance Meetings (to be held at least twice-yearly at icare's discretion); and

(D) Scheme-Wide Risk Workshops (to be held from time to time in icare's discretion).

(ii) Other meetings may be established at the discretion of icare, including sub-committees of the above forums. The Claims Service Provider must make all reasonable efforts to ensure specific Personnel or Personnel of the requested seniority and experience are available to attend such meetings.

(b) **Portfolio and Performance Meeting**

(i) The Portfolio and Performance Meeting is an integral part of the Governance Framework. The members of this meeting will:

(A) include the Partnering and Performance Managers or their permitted delegates; and

(B) have primary responsibility for monitoring performance (including compliance) commitments under this Contract to support delivery of the Services.

(ii) Meeting members will work collaboratively to build and maintain a high-performance management culture to achieve Performance Measures.

(iii) Governance of the Portfolio and Performance Meeting will be supported by a charter, to be developed jointly by icare and the Claims Service Provider, which outlines, amongst other things, topics for discussion, location, cadence, members, quorum requirements, setting of the agenda, reporting requirements and the accountability and responsibilities of attendees and cadence (**Portfolio and Performance Meeting Charter**). The icare Partnering and Performance Manager and Claims Service Provider Partnering and Performance Manager may agree amendments to the Portfolio and Performance Meeting Charter, provided that the meeting meets its required purposes in accordance with this section 3.2(b).

(iv) Unless otherwise specified in the Portfolio and Performance Meeting Charter, in addition to Claims performance, including assessment of the Performance Measures under the Contract, the Portfolio and Performance Meeting or its subcommittees will discuss performance in the following areas:

(A) (***Quality Measures***) the Claims Service Provider's performance against the Quality Measures;

(B) (***customer***) oversight of the customer experience;

(C) (***people***) workforce strategies and operations related to people, capabilities and culture;

(D) (***financial***) suitably controlling Scheme liabilities to ensure Scheme sustainability and to manage risks for decisions with large potential financial impacts;

(E) (***budget***) Claims Service Provider operating costs and their relation to the budget submitted as part of the Annual Business Plan (described further in section 3.3);

(F) (***risk management***) quality and compliance;

(G) (***service delivery***) operational performance and delivery of Services;

(H) (***projects***) performance and delivery of Projects;

(I) (***remuneration***) review of Remuneration; and

(J) (***Operational Measures Register***) the Operational Measures Register, including the performance of the Claims Service Provider on each of the Operational Measures and any changes to be made to the Operational Measures.

(v) At each meeting, members will have access to the Portfolio and Performance Meeting Charter along with performance reports and any applicable audit reports.

Attachment 3.03 ("*Assurance Reviews*") and Attachment 3.05 ("*Reports Matrix*") should be referred to.

(c) **Portfolio and Performance Meeting sub-committees**

(i) The members of the Portfolio and Performance Meeting will establish sub-committees as required. Sub-committees may be formed to provide a focused approach through additional governance and oversight to help address areas of performance, innovation or compliance risk.

(ii) The membership and governance of each sub-committee will be through an agreed charter developed by the sub-committee.

(d) **Strategic Leadership Meetings**

(i) Strategic Leadership Meetings will be held to consider matters of a strategic nature relating to the Claims Service Provider and the management of the Workers Compensation portfolios within the Workers Compensation Scheme, as well as matters that have been escalated to the Strategic Leadership Meetings.

(ii) The members of the Strategic Leadership Meeting will:

(A) include the Authorised Representatives or their permitted delegates and may include, at the invitation of either Authorised Representative or their permitted delegate, the Partnering and Performance Managers in an advisory role; and

(B) unless otherwise specified in the Strategic Leadership Meeting Charter, consider and discuss, amongst other things:

(1) Scheme trends, global industry trends and themes arising from joint forums involving Other Claims Service Providers, and their application to the strategic direction of the relationship;

(2) progress of and amendments to the draft annual business plan developed under section 3.3;

(3) the Claims Service Provider's performance against the current Annual Business Plan and the Outcome Measures;

(4) any existing or proposed initiatives that are part of the innovation framework;

(5) the applicability of the current Annual Business Plan and any appropriate adjustments; and

(6) operational issues that have been escalated to the meeting and key risks which may impact on the strategic relationship and/or initiatives detailed within the current Annual Business Plan.

(iii) Governance of the Strategic Leadership Meeting will be supported by a charter, to be developed jointly by icare and the Claims Service Provider, which outlines amongst other things, topics for discussion, location, cadence, members, quorum requirements, reporting requirements, setting of the agenda and the accountability and responsibilities of attendees and cadence (**Strategic Leadership Meeting Charter**). The Authorised Representatives may agree amendments to the Strategic Leadership Meeting Charter provided that the meeting meets its required purposes in accordance with this section 3.2(d).

(e) **Scheme-Wide Performance Meetings**

(i) Scheme-Wide Performance Meetings will be a joint forum consisting of representation from icare, the Claims Service Provider and all Other Claims Service Providers.

(ii) Scheme-Wide Performance Meetings will be held to consider strategic matters relevant to the Scheme and future planning.

(iii) The Claims Service Provider must make all reasonable efforts to ensure that the Claims Service Provider Authorised Representative and Claims Service Provider Partnering and Performance Manager attend the Scheme-Wide Performance Meetings.

(iv) Scheme-Wide Performance Meetings may involve a co-design forum to ensure that icare and the Claims Service Providers manage Third Party Service Providers effectively and efficiently.

(f) **Scheme-Wide Risk Workshops**

(i) Scheme-Wide Risk Workshops will be a joint forum consisting of representation from icare, the Claims Service Provider, all Other Claims Service Providers and other stakeholders invited by icare.

(ii) Scheme-Wide Risk Workshops will be held when icare considers that it is necessary for all members of the Scheme to come together and consider Scheme-wide issues that may impact the performance of the Claims Service Provider and all Other Claims Service Providers, Scheme-wide capability and other items that icare considers appropriate.

(iii) Unless otherwise advised by icare, the Claims Service Provider must make all reasonable efforts to ensure that Scheme-Wide Risk Workshops are attended by:

(A) the Claims Service Provider Authorised Representative;

(B) Claims Service Provider Partnering and Performance Manager; and

(C) senior employees within the Claims Service Provider that have oversight of matters relevant to the workshops.

3.3 Annual Business Plan

(a) **Content of the Annual Business Plan**

(i) The Claims Service Provider must develop a draft annual business plan for icare's Approval that sets out, in respect of:

(A) the first Calendar Year of the Contract; and

(B) each subsequent Calendar Year,

(each, the **Applicable Calendar Year**), jointly developed goals, objectives and initiatives between icare and the Claims Service Provider, and the content required in section 3.3(a)(iii).

(ii) To develop the draft annual business plan, the Claims Service Provider must consider the discussions at, and outcomes of, the meetings described in section 3.2.

(iii) Unless otherwise agreed by icare and the Claims Service Provider, the Claims Service Provider's Annual Business Plan must be prepared in accordance with the Workers compensation licensed insurer business plan guidelines published by SIRA (as amended or replaced from time to time), and include:

(A) icare and the Claims Service Provider's jointly established objectives, strategies, milestones and actions;

(B) icare and Claims Service Provider commitments on shared goals and objectives regarding the performance of the Contract;

(C) initiatives for improving Claims Management outcomes and Portfolio performance, including remediation activity and plans;

(D) suggested new or updated Operational Measures and associated target performance levels to monitor progress to achieving those objectives and delivering on the strategies;

(E) details of Personnel to support Service delivery and other information as agreed with icare, divided into management of physical Injury Claims and Primary Psychological Injury Claims;

(F) budget for operations for the Calendar Year divided into management of Physical Claims and Psychological Claims and meeting the other requirements described in Schedule 2 ("*Remuneration*");

(G) human resources and capability uplift plan - this is to include how the Claims Service Provider will be operationalising the professional standards;

(H) communication strategies and plans;

(I) information technology plan;

(J) stakeholder engagement updates and planning, as advised by icare;

(K) projected case load numbers per full-time employee and case type;

(L) planned improvements and innovations over the Applicable Calendar Year and how they will achieve the Workers Compensation Scheme Principles and optimise performance. This should include any initiatives that are part of the innovation and strategic investment under Schedule 2 ("*Remuneration*");

(M) Value Added Services to be offered to Employers and how this will benefit the Employer, proposed outcomes, how they will be measured and reported;

(N) corporate changes that may impact on the operations under the Contract;

(O) operational and organisational risks (including the identification, assessment, and mitigation of those risks); and

(P) the Claims Service Provider's internal assurance plan, as described in clause 4.4(b).

(b) **Delivery and approval**

(i) The Claims Service Provider must provide to icare:

(A) a draft annual business plan applicable to the first Applicable Calendar Year and second Applicable Calendar Year of the Contract by 1 September 2023; and

(B) a draft annual business plan for subsequent Applicable Calendar Years by the date that is the earlier of:

(1) 1 September of the Calendar Year that is the year prior to the Applicable Calendar Year;

(2) the date of the last scheduled Strategic Leadership Meeting of the previous Applicable Calendar Year,

unless otherwise agreed with icare.

(ii) Unless otherwise agreed by the parties, when the Claims Service Provider provides to icare the draft annual business plan described in section 3.3(b)(i), the Claims Service

Provider must give icare a presentation on the draft business plan to enable icare to understand what it contains.

(iii) icare will review the draft annual business plan and advise the Claims Service Provider if:

(A) it is Approved by the icare Authorised Representative; or

(B) the icare Authorised Representative considers that amendments are required,

and the parties will work together to implement any required amendments before the commencement of the Applicable Calendar Year.

(iv) Once Approved, the draft annual business plan will be the Annual Business Plan for the Applicable Calendar Year. The Annual Business Plan is the primary vehicle to manage and deliver the joint objectives of icare and the Claims Service Provider during the Applicable Calendar Year, and may be amended by agreement of the icare Authorised Representative and the Claims Service Provider Authorised Representative.

4. Performance

4.1 Framework

(a) The Claims Service Provider's performance will be assessed against:

(i) the Performance Measures as stated in section 4.2 of this Schedule;

(ii) compliance with any and all requirements and obligations detailed within the Contract; and

(iii) conduct exhibited in the effective delivery of services to customers in accordance with the Contract, Schedule 1 ("*Customer Engagement and Claims Management Service*") and this Schedule.

(b) Performance Measures under this Contract will consist of:

(i) Operational Measures;

(ii) Quality Measures; and

(iii) Outcome Measures.

(c) The Claims Service Provider must:

(i) monitor and manage its performance through self-assessment against the applicable Performance Measures; and

(ii) report on its performance against the Performance Measures as specified in this Schedule and Attachment 3.05 ("*Reports Matrix*") for which the Claims Service Provider has been allocated reporting responsibility.

4.2 Performance Measures

(a) **Operational Measures**

(i) The Operational Measures are designed to drive ongoing improved performance in the delivery of Claims Management and related Services by the Claims Service Provider. The Operational Measures are not relevant to determining the remuneration payable to the Claims Service Provider under Schedule 2 ("Remuneration").

(ii) The Operational Measures include measures related to:

(A) emerging or current operational issues of concern or focus for the Scheme; and

(B) ongoing compliance measures that icare considers require specific focus and attention by the Claims Service Provider.

(iii) Attachment 3.01 ("Operational Measures") will include the following detail for each Operational Measure:

(A) the frequency of assessment of the Operational Measure (for example, monthly, Quarterly, bi-annually or annually);

(B) the methodology for assessment including any specific inclusions or exclusions of Claims or types of Claims or Services;

(C) the target for the Operational Measure; and

(D) whether the Claims Service Provider or icare is responsible for reporting on the performance of the Operational Measure.

(iv) icare may update Attachment 3.01 ("Operational Measures") from time to time and inform the Claims Service Provider of any changes at the Portfolio and Performance Meeting or by written notice.

(v) For the purposes of clause 7.4 (Performance Measures) of the Contract Terms, the Claims Service Provider will fail to meet an Operational Measure if its performance falls below the target for that measure, as set out in Attachment 3.01 ("*Operational Measures*").

(b) **Quality Measures**

(i) The Quality Measures will assess the Claims Service Provider's compliance and conduct in the delivery of Claims Management and related Services under the Contract.

(ii) icare will determine which minimum standards will be included within the Quality Measures based on key areas of compliance or conduct which are of concern or focus for the Scheme and/or the Claims Service Provider in a given period. icare will set the target for each Quality Measure on or around the minimum standard that icare expects the Claims Service Provider to achieve.

(iii) icare may maintain a Quality Measures register ("**Quality Measures Register**"), which will include the following detail for each Quality Measure:

(A) the commencement date of the Quality Measure and the date on which the first assessment will be undertaken;

(B) the frequency of assessment of the Quality Measure (monthly, Quarterly, bi-annually, annually);

(C) the methodology for assessment;

(D) the expected level of performance for the Quality Measure; and

(E) whether the Claims Service Provider or icare is responsible for reporting on the performance of the Quality Measure.

(iv) For the purposes of clause 7.4 (Performance Measures) of the Contract Terms, the Claims Service Provider will fail to meet a Quality Measure if its performance falls below the expected level of performance for that measure, as set out in Schedule 2 ("*Remuneration*") including its Attachments.

(v) If the Claims Service Provider fails to meet any Operational Measure, icare may include that measure as a Quality Measure in accordance with the time period specified in Schedule 2 (Remuneration).

(vi) The icare Authorised Representative may add to, remove, or change any of the Quality Measures after giving the Claims Service Provider prior notice in accordance with the time period specified in Schedule 2 (Remuneration).

(c) **Outcome Measures**

(i) The Outcome Measures reflect the key outcomes icare is seeking from the Claims Service Provider. The targets for each Outcome Measure will be targets that are aimed at delivering overall value to the Scheme. However, unlike Operational Measures and Quality Measures, there is no requirement for the Claims Service Provider to achieve the targets for each Outcome Measure. If a target for an Outcome Measure is not achieved, the Claims Service Provider will not be eligible to receive additional remuneration that is contingent on achieving that target.

(ii) The icare Authorised Representative may add to, remove, or change any of the Outcome Measures after giving the Claims Service Provider prior notice in accordance with the time period specified in Schedule 2 (Remuneration).

4.3 Performance Management

(a) **Reporting**

(i) **Overview**

(A) The Claims Service Provider must provide icare with the reports set out in Attachment 3.05 ("*Reports Matrix*").

(B) The reports required under section 4.3(a)(i)(A) and section 4.3(a)(i)(F), combined with the results of reviews and assurance activities undertaken in accordance with Attachment 3.03 ("*Assurance Reviews*"), will help inform icare's assessment of the Claims Service Provider's performance and compliance with the Contract.

(C) The Data insights from the performance reporting, accompanied by any technical, business, market and industry insights, will inform any future actions or strategies icare takes to improve performance and compliance with the Contract.

(D) icare will review the content of reports submitted to it by the Claims Service Provider to support any discussions on operational performance and compliance through the applicable Governance Meeting.

(E) icare may consider any significant issues arising from the review of reporting for inclusion in the PMR.

(F) icare may request ad hoc reports from time to time, or add or delete a report to or from the Reports Matrix, and the Claims Service Provider will provide these reports to icare at no cost to icare and in accordance with the timeframes requested.

(ii) **Reporting timeframes and format**

(A) The Claims Service Provider must submit to icare the reports in the prescribed or agreed format by the due date specified in Attachment 3.05 ("*Reports Matrix*") or, if no due date is specified, within 7 Business Days of the end of each reporting period. The Claims Service Provider must submit the reports via

email to icare's account mailbox for the Claims Service Provider, unless otherwise advised by icare from time to time.

(B) Where no format is prescribed by icare, the Claims Service Provider must submit the reports in PDF, Excel or Word format.

(C) In respect of the monthly reports in section 1.1 of Attachment 3.05 (Reports Matrix) that are asterisked (the **Relevant Monthly Reports**):

(1) the parties will, for the period of six months immediately after the Services Commencement Date, monitor the Claims Service Provider's achievement of the timeframes for submission of the Relevant Monthly Reports by the due date specified in section 1.1 of Attachment 3.05 and the achievability of meeting these timeframes (taking into account the logistics of their preparation and submission); and

(2) at the end of this six month period, icare will review the due date for the submission of the Relevant Monthly Reports in consultation with the Claims Service Provider and consider whether any changes to any of those due dates should be made having regard to the experience of the preceding six months.

(iii) **Reports produced by icare for the Claims Service Provider**

icare may provide reports and information to the Claims Service Provider from time to time as icare considers appropriate and informative, concerning matters such as the overall performance of the Scheme and the Claims Service Provider's individual performance.

(b) **Performance Management Register (PMR)**

(i) **Overview**

(A) icare will maintain the PMR, which is designed to identify performance issues and monitor and track resolution of the performance issue by the due date.

(B) In respect of all items added to the PMR that require performance management activities, icare will, in consultation with the Claims Service Provider, assign:

(1) a priority level (being high, medium or low priority);

(2) performance management activities required; and

(3) a due date.

(C) The PMR will be tabled for review and discussed at each Portfolio and Performance Meeting and/or sub-committee as required.

(D) For the avoidance of doubt, icare may, with effect from the Commencement Date, transfer to the PMR any items (and associated information) that, immediately prior to the Commencement Date, were on a performance management register (or equivalent register) established under a Pre-Existing Agreement.

(ii) **Priority Level of PMR items**

If, in respect of an item on the PMR that requires performance management activities, either:

(A) progress indicates that the item is unlikely to be successfully resolved by the due date; or

(B) the timeframes described in a Remediation Plan (if applicable) are not met,

then, without limiting icare's rights under subclause 53.2 or clause 59 of the Contract Terms, icare may choose to escalate the priority level of the item on the PMR and re-determine the performance management activities associated with the item.

(iii) **Resolution of PMR items**

(A) icare will note an item as resolved in the PMR upon the Claims Service Provider providing sufficient evidence to icare that the item has been resolved.

(B) Following resolution of an item, icare may perform an audit to confirm resolution or require the Claims Service Provider to provide ongoing evidence that there has been no recurrence of the issue to which the resolution related.

(C) icare will determine the actual resolution date based for each item based on the evidence of the Claims Service Provider and any further investigations or evidence.

(iv) **Relationship with the Operational Measures Register**

In addition to icare's right to turn Operational Measures into Quality Measures in section 4.2(b)(v), icare has discretion to move any Operational Measure described in the Operational Measures Register to the Performance Management Register.

(c) **Remediation Plan Direction**

(i) Without limiting its other rights under the Contract, if the Claims Service Provider fails to undertake performance management activities allocated to it in relation to an item on the PMR by the due date, icare may issue a Remediation Plan Direction in accordance with clause 53.2 of the Contract Terms.

(ii) icare will include in a Remediation Plan Direction raised under this section 4.3, or otherwise under clause 53.2 of the Contract Terms:

(A) the issue;

(B) resolution;

(C) responsible party;

(D) due date; and

(E) risks.

4.4 Quality Management Framework

(a) The Claims Service Provider must operate a Quality Management Framework that incorporates documented procedures to ensure the consistent delivery of Services, compliance with applicable Laws and the Claims Service Provider's other obligations under the Contract with a focus on continuous improvement. This includes:

(i) ensuring that icare's Workers Compensation Schemes Claims Quality Assurance Framework in Attachment 3.02 ("*Workers Compensation Schemes Claims Quality Assurance Framework*") is implemented (including the performance of the roles and responsibilities allocated to the Claims Service Provider in that document);

(ii) ensuring that the addenda to icare's Workers Compensation Schemes Claims Quality Assurance Framework and test elements are implemented and appropriately utilised, including management of scheduled, Quarterly updates/changes;

(iii) ensuring that the Quality Management Framework integrates and addresses the key obligations and requirements set out in Attachment 3.03 ("*Assurance Reviews*");

(iv) conducting periodic systematic reviews that:

(A) assess the Claims Service Provider's performance to identify gaps requiring improvement; and

(B) develop and implement actions or development strategies where gaps or opportunities have been identified;

(v) recording and retaining the history of such reviews, including data, review workbooks, findings, reports and improvement plans and providing these to icare monthly or at such other frequency as contemplated in accordance with Attachment 3.05 ("*Reports Matrix*"); and

(vi) tracking the implementation of continuous improvement activities, recording progress and outcome.

(b) As part of the Annual Business Plan, the Claims Service Provider must provide to icare for its approval, a copy of the Claims Service Provider's internal assurance plan detailing the audits, reviews or other assurance activities that it will undertake in each Calendar Year to meet the requirements of icare's Workers Compensation Schemes Claims Quality Assurance Framework, Attachment 3.03 ("*Assurance Reviews*") and any other reviews required to ensure the consistent delivery of Services, compliance with applicable Laws and the Claims Service Provider's other obligations under the Contract.

(c) For the avoidance of doubt:

(i) the scoring system described in icare's Workers Compensation Schemes Claims Quality Assurance Framework will be relevant to determining the Claims Service Provider's performance against the Operational Measures, but icare's Workers Compensation Schemes Claims Quality Assurance Framework will not be the only means of assessing the quality of Services provided by the Claims Service Provider under the Contract; and

(ii) icare will undertake Claims Service Provider-specific quality assurance checks to ensure all Services provided under the Contract are operating as intended.

(d) icare will conduct deep dive targeted reviews in specific areas of concern from time to time where support is required by the Claims Service Provider, and the Claims Service Provider agrees to co-operate with reasonable requests made by icare in relation to the any support and assistance needed to conduct the review.

(e) If the Claims Service Provider undertakes, or is instructed by icare to undertake, additional internal audits, reviews or other assurance activities not identified in its internal assurance plan in relation to the Services provided, then the Claims Service Provider must provide icare with a copy of the terms of reference and report and associated data for each internal audit, review or other assurance activity undertaken.

(f) To the extent that implementation of icare's Workers Compensation Schemes Claims Quality Assurance Framework in Attachment 3.02 ("*Workers Compensation Schemes Claims Quality Assurance Framework*") allocates roles or responsibilities to icare or its Personnel, icare will not have obligations under the Contract to perform those roles and responsibilities, or any liability to the Claims Service Provider for any failure to perform them. However, icare acknowledges that any roles or responsibilities it has under the Workers Compensation Schemes Claims Quality Assurance Framework may be dependencies on which the Claims Service Provider relies in order to perform its obligations in relation to the Workers Compensation Schemes Claims Quality Assurance Framework.

4.5 Audits, Reviews and Assurance Requirements

(a) Overview

(i) icare may carry out audits and inspections in accordance with clause 46 of the Contract Terms.

(ii) Attachment 3.03 ("*Assurance Reviews*") sets out various review and assurance requirements to be undertaken by the Claims Service Provider. The initial reviews and assurance requirements are set out in Attachment 3.03 ("*Assurance Reviews*"). Where icare considers that changes to the Attachment are required in order to provide appropriate assurance regarding the Claims Service Provider's performance of the Contract, icare may update the Attachment by providing notice to the Claims Service Provider at least 4 months prior to the commencement of the Calendar Year in respect of which those changes will become applicable.

(iii) The Claims Service Provider will perform the reviews and assurance requirements identified in Attachment 3.03 ("*Assurance Reviews*") as part of the Services, as set out in that Attachment and the Contract.

(iv) The Claims Service Provider must provide the detailed findings of, and data relating to, the reviews and assurance requirements identified in Attachment 3.03 ("*Assurance Reviews*") to icare within the timeframes set out in that Attachment.

(v) If:

(A) a non-compliance is identified as part of any reviews and assurance requirements identified in Attachment 3.03 ("*Assurance Reviews*") or in the internal assurance plan; or

(B) an adverse audit comment arises from an Internal Control audit conducted by an Approved Auditor under section 4.6(a)(ii),

then icare will consider whether the item will be recorded on the PMR.

(vi) If icare records an item on the PMR under section 4.5(a)(v):

(A) icare will, in consultation with the Claims Service Provider, allocate to the item an appropriate risk rating and timeframe for resolution and monitoring; and

(B) the Claims Service Provider must:

(1) rectify the item and the root cause of the item in the required timeframe;

(2) provide monthly updates to the PMR and include them on the agenda for the Portfolio and Performance Meeting; and

(3) re-review the affected item and report its findings to icare.

(vii) icare or its agent may re-audit any issue identified under section 4.5(a)(v) after the Claims Service Provider has rectified the issue.

(viii) The Claims Service Provider will provide icare, as part of the Annual Business Plan, with a copy of its internal assurance plan detailing the reviews and assurance requirements it will undertake in each Calendar Year, to meet the requirements of Attachment 3.03 ("*Assurance Reviews*") following the strategic review.

(b) No limitation of icare's rights under the Contract

(i) Nothing in this Schedule including its Attachments, prevents icare from, or requires icare to delay in, doing, or taking preliminary steps to do, either of the following:

(A) exercising its rights under the Contract, including under clauses 53 or 59 of the Contract Terms; or

(B) exercising its rights under the Contract to investigate or conduct an audit regarding a non-compliance or Conduct Risk incident.

(c) In respect of any audit or other investigation contemplated in section 4.5(b)(i)(B):

(i) the Claims Service Provider will assist icare in the conduct of any audit or other investigation activity to identify underperformance, non-compliance or Conduct Risk incident; and

(ii) icare may require an external audit to verify compliance with the Contract and the Law.

4.6 Internal Controls

(a) **Overview**

The Internal Controls:

(i) must be designed by the Claims Service Provider to protect the assets of icare and ensure that adequate controls, and appropriate policies and procedures are in place so that the Claims Service Provider meets its obligations and delivery on customer outcomes; and

(ii) will be tested by the Approved Auditor engaged by icare annually in accordance with Attachment 3.04 ("*Internal Controls Framework*").

(b) **Scope**

(i) The Claims Service Provider must have in place and implement an Internal Controls framework in the form set out in Attachment 3.04 ("*Internal Controls Framework*"). The Claims Service Provider and icare acknowledge that, in all material respects, the control procedures identified in Attachment 3.04 ("*Internal Controls Framework*") have been designed to provide reasonable, but not absolute, assurance that the Internal Controls' objectives will be achieved.

(ii) icare will stipulate in the Internal Controls framework the minimum system controls that are built into the Claims Technology Platform. The Claims Service Provider must consult with icare and provide for icare's confirmation details of additional manual or automated internal controls that it proposes to implement in order to achieve the applicable control objectives (**Internal Controls**).

(iii) On an annual basis, icare will engage the Approved Auditor to perform ASAE 3150 assurance engagements over the Internal Controls in relation to Claims Management functions outsourced by icare for the year ending 30 June each year.

(iv) The Claims Service Provider must ensure that the procedures under its Internal Controls framework are in place from 1 July of each year to 30 June of the following year and operate effectively and continuously.

(v) The Claims Service Provider is responsible for:

(A) the design of the Internal Controls; and

(B) the implementation and maintenance of the Internal Controls and supporting procedures and artefacts to operationalise the controls.

(vi) icare will document and add exceptions identified as a result of the ASAE 3150 assurance engagements described in section 4.6(b)(ii) to the PMR for remediation by the Claims Service Provider.

(vii) The Claims Service Provider must ensure that:

(A) documented controls address the stated risks and control objective(s);

(B) Internal Controls are reviewed and tested at the frequency specified in Attachment 3.03 ("*Assurance Reviews*") using a risk-based approach;

(C) the declaration in the form of Schedule 6 ("*Claims Service Provider Declaration*") is completed, signed and provided to icare in accordance with 56.5 of the Contract Terms;

(D) exceptions identified as part of the ASAE 3150 assurance engagements described in section 4.6(b)(ii) are addressed and remediated within provided timeframes; and

(E) reports in relation to the PMR are delivered to icare as agreed.

(c) **Amendments**

(i) In addition to the testing of Internal Controls under Attachment 3.04 ("*Internal Controls Framework*"), icare may, in consultation with the Claims Service Provider, update (including introducing new) risks, control objectives and system controls, and Attachment 3.04 ("*Internal Controls Framework*") will be updated accordingly by notice to the Claims Service Provider.

(ii) If icare updates any risks, control objectives or system controls under section 4.6(c)(i), the Claims Service Provider must promptly:

(A) amend its Internal Controls if it considers any amendments are necessary to respond to icare's updates; and

(B) provide those amendments to icare for information.

5. Attachments

Attachment 3.01 ("*Operational Measures*")

Attachment 3.02 ("*Workers Compensation Schemes Claims Quality Assurance Framework*")

Attachment 3.03 ("*Assurance Reviews*")

Attachment 3.04 ("*Internal Controls Framework*")

Attachment 3.05 ("*Reports Matrix*")

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Workers Compensation Schemes (Nominal Insurer and Treasury Managed Fund) Claims Quality Assurance Framework

V.2.0

Version Control

Document Name & Version	Workers Compensation Claims Quality Assurance Framework v1.0
Document Owner	Kate Molloy, Head of Quality Assurance
Approving Authority	NI Leadership Team and GM, Compliance Assurance and First Line Risk
Last Approval Date	16/11/2021
Review Frequency	Annual

Document History

Version	Author	Change Summary	Date
	Kate Molloy	First draft for review	30/04/2021
	Kate Molloy/Jonathan Wigham	Second draft for review	13/08/2021
	Kate Molloy	Final Draft with IA recommendations incorporated	16/11/2021
2.0	Kate Molloy	Final	10/12/2021

Contents

1. Purpose

The Workers Compensation Claims Quality Management Framework is critical in underpinning the Workers Compensation operations. It ensures that the work performed is consistent, transparent and helps icare identify and apply continuous improvements in a systematic way.

This document provides a framework to facilitate the appropriate design and consistent application of the Workers Compensation Claims Quality Assurance Program which is used to monitor performance and the effectiveness of services being provided, identify staff training gaps, provide input to the Quality Assurance Framework cycle and for process improvement/re-engineering.

Quality Assurance (QA)reviews provide useful insights into relevant claims management issues and themes which can then be used as inputs into a continuous improvement process (along with other inputs such as customer feedback, complaints and return to work (RTW) results).

The Workers Compensation Claims Quality Assurance Framework (QAF) and associated activities focus on:

- Informing management of the qualitative aspects of performance
- Identifying trends and issues relating to quality of key claims management activities
- supporting effective claims and injury management practices
- providing assurance over management of key risks
- managing performance, improving quality and the continuous improvement of services
- fine tuning QA and other assurance activities

This QAF is not intended to be an overarching, end-to-end framework to assess all claims management activities, cohorts of claims etc and therefore other complimentary reviews will be required.

The QA reviews prescribed in this framework sits alongside should not be the only form of quality assurance/assurance activity undertaken by icare and the Claims Service Providers to ensure contract requirements/scheme objectives are met.

2. Quality Assurance Framework (QAF) Design Fundamentals

The Workers Compensation Claims Quality Assurance Framework has been designed with the following objectives or guiding principles in mind:

1. To support the overall objectives of:
    a. Workers Compensation Legislation and Regulation
    b. SIRA Standards of Practice
    c. Workers Compensation Guidelines
    d. icare Service Model and Service Expectations*
    e. Relevant Knowledge Articles

2. Contributing to the achievement of SIRA customer service conduct principles.

Principle 1:	The insurer must keep customer interactions simple and accessible to make the experience easier, so that the focus is on recovery and resolution. This means:

Be easy to engage and efficient	• customers should only have to provide or ask for information once • information is clear and understandable enabling a streamlined experience • complexity is reduced by communicating in simple language • information is timely and accessible • customers will experience visible support and information throughout the customer journey.
Principle 2: Act fairly, with empathy and respect	The insurer must be respectful of people's individual circumstances and needs and support them accordingly. This means: • customers are treated fairly, receiving the same quality services, every time • customers are shown compassion and understanding of their individual situation customers are treated with dignity, empathy, and respect.
Principle 3: Resolve customer concerns quickly, respect customers' time and be proactive	The insurer must be proactive in supporting recovery and resolution. This means: • resolve customer concerns at the first opportunity • customers are supported early, leading to better recovery outcomes and resolution • customers' time is valued customers will be contacted when they need to know something.
Principle 4: Have systems in place to identify and address customer concerns	The insurer must have systems in place to engage customers and listen to concerns and suggestions. This means: • customer views will be sought on service design and improvement • ensure transparency in addressing systematic issues as they are identified and rectified continuous improvement systems are in place.
Principle 5: Be accountable for actions and honest in interactions with customers	Customers will receive an acknowledgement when things don't go to plan. This means: • customers will receive an acknowledgment when harms are caused, when customer expectations are not met or when legislative breaches occur • poor service or behaviour will be acknowledged, and action taken.

3. Understanding the claims and customer experience. A fundamental outcome of the QAF will result in measurement from both a 'compliance perspective' (e.g. on time decision making) and a 'quality of engagement perspective' (e.g. quality engagement with the customer through conversation).

4. To identify, escalate and support effective management of risk and areas for improvement

5. To enable Claims Service Providers to be assessed against contract KPIs/other contract requirements

**icare Service Expectations refer to standards of service which are defined by icare in Knowledge Articles and which go beyond or clarify the requirements of the Legislation or Regulatory Instruments. Claims Managers are contractually obliged to act in accordance with these expectations*

3. Quality Assurance Principles

The Workers Compensation Claims QAF is a principle-based framework that aligns with icare's specific quality management principles and ISO 9001:2016.

Customer Outcome Focused	Identification and management of undesired impacts on our customers, reputation, operations, and financial wellbeing. Identification of "desirable" or "upside impacts" with a view to scale them across the business.
Leadership	The strategy, direction and success are dependent on leadership. Management's clearly communicated vision and purpose is key to ensuring business improvement and people engagement with QA implementation.
Accountability	Workers Compensation Claims and Claims Service Providers have accountability for operational quality and risk management with clearly defined roles and responsibilities. The QAF recognises and contributes to identifying opportunities for capability development of frontline employees and assists in the development and delivery of training to upskill frontline employees.'
Risk Based	Supports a risk-based approach to targeting processes and assurance activities. Various business performance metrics are used to identify areas for further QA review.
Evidence Based	Involves effective, at times complex, and conscientious decision-making which is based on sound evidence, data, relevant legislation and regulations, SIRA's Standards of Practice (SOP) and icare service expectations.
Transparency	Leverages available information, data, and exception reporting to improve transparency. Promotes a no-blame culture that values transparency and prioritises learning from mistakes.
Process Approach	Recognises that consistent and predictable results are achieved when QA activities are interrelated processes. The core claims management activities are assessed separately but consideration is also given to how they fit together.

Segregation of Duties	Appropriate segregation of duties to manage risks appropriately.
Assurance	Assurance to the Board that Workers Compensation Claims is fulfilling its expectations in providing quality service.
Continual Improvement	Supports the focus on improving the way activities are done on a regular basis.
Engagement of People	Minimum expectations are set around the feedback loop to ensure feedback from QA reviews is passed on to front-line staff

4. Quality Assurance Framework

The Workers Compensation Claims QAF includes as an output of the review process, the identification of processes requiring remedial action and/or opportunities to further improve processes.

The feedback loop includes mechanisms to ensure review and continual update of Knowledge Articles, operating practices and icare Service Expectations and will also be part of the feedback loop for workers compensation improvement initiatives.

4.1 Core Elements

Planning

- Identify focus areas for QA activities based on interactions with the Workers Compensation Claims Leadership teams, Claims Service Managers and outputs from other assurance/performance metrics e.g. compliance dashboards
- Capture internal and external views on focus areas and effectively prioritise QA activities
- Consideration to be given to:
    - Strategic outcomes and themes for icare
    - Metrics
    - External factors (regulator, industry and/or market development)
    - Key risks
    - Value chain activities

Implementation

a) File Review

- Review relevant claims management/injury management activities
- Monthly review cycle
- Two types of QA review:
    1. Routine Claims Review – review multiple activities on a file to a regular schedule
    2. Targeted Review – review specific activities/cohorts of claims
- Two lenses are applied when reviewing claims management/injury management activities:

1. **Process Compliance** - were legislative, regulatory, and business process requirements met

2. **Claims Management** - were activities managed in the most effective way to facilitate RTW and return to health (RTH) and provide a positive customer experience (were the icare service expectations met?)

b) Sampling

The sampling methodology used will be consistent across Claims Service Providers for number and proportion of claims reviewed.

See Addendum for specific detail on sampling.

Routine QA Reviews

This involves a monthly review of open files, assessing process compliance, claims management and customer outcome.

The regular reporting of findings and actions assists in identifying areas of risk and driving performance improvement.

Targeted reviews

Review specific activities/cohorts of claims. Areas for targeted reviews will be identified during formal business planning as well as throughout the year from results of other reviews/assurance activities (e.g. systemic issues requiring more detailed review), customer feedback (e.g. trends identified through complaints analysis/NPS), data review (e.g. number of Case Manager transfers/handover), performance reporting from Claims Service Providers (e.g. turnover/return to work metrics) and/or other performance results (e.g. performance dashboards), both within Workers Compensation Claims and icare more broadly.

Random sampling and risk-based sampling may be considered for this type of review.

Targeted reviews will include a review of claims files, system data, call recordings and an assessment of capabilities. The sampling methodology will be continuously reviewed and is subject to change at icare's discretion. Changes will be communicated through the quarterly updates to the Addendum.

Review/Evaluation

- QA reviews will be recorded in the scoresheet provided by icare
- Calibration sessions between icare and Claims Service Providers will be held to ensure consistency in reviewing
- Guidance notes to support the QA Framework will be provided as required
- QA reviews will be completed, and findings/reports submitted to icare by 10th business day of the month
- Performance tracking will be undertaken
- Improvement actions will be monitored for closure as appropriate
- This framework will be reviewed annually with updates made as appropriate
- The Addendum will be reviewed quarterly with updates made as appropriate

4.2 Test Elements

The purpose of the QAF is to review the key claims management activities which support effective claims and injury management practices, provide assurance over the management of key risks, and contribute to continuous improvement of services.

Assessment of these key claims management activities is designed to support the overall objectives of the Workers Compensation legislation, regulation, and guidelines, SIRA Standards of Practice, SIRA Customer Service Principles, the icare Service Model and Service Expectations and relevant knowledge articles.

Where non-compliance is noted for an activity not specifically covered by the QA Framework (e.g. data entry error, privacy breach etc), this will be escalated for remediation in line with relevant Claims Management Agreements, legislation and icare service expectations.

These test elements will be continuously reviewed and are subject to change at icare's discretion. Changes will be communicated through quarterly updates to the Addendum or communicated by the QA Team by way of guidance/clarification emails.

Test elements can be found attached to the Addendum.

4.3 Scoring

A simple scoring mechanism will be used to score reviews. Questions have been structured such that a "yes" answer is a positive score and indicates compliance with legislation/guidelines/Standards of Practice/service expectations etc and a "no" answer, a negative score suggesting non-compliance. Findings will be presented as a percentage of Yes answers (i.e. demonstrates compliance with an activity).

Where a score of "Yes" or "No" is not appropriate, "N/A" will be used. Elements attracting a "N/A" rating, will not impact the overall score.

The scores will be used to determine if Key Performance Indicators (KPIs)/Service Standard targets have been met. Additionally, improvement in scores over time will be expected for underperforming areas as claims management activities improve.

The final score will be an overall compliance score however, where possible, the score will be broken down to the next level to help delineate between process compliance and claims management.

The scoring methodology will be regularly reviewed and is subject to change at icare's discretion. Changes will be communicated through quarterly updates to the Addendum.

4.4 Reporting

A structured approach to reporting facilitates a focus on continuous improvement.

Standard QA Report

- Report is prepared and distributed at regular intervals (usually monthly)
- Agent comparison provided
- Reports provided to Claims Service Providers and Workers Compensation Claims Leadership teams with QA results/findings and recommendations. A management response is required, and this will be tracked to successful completion
- Performance/report to be discussed at monthly operational/performance meetings

Performance Tracking

- All QA reports include a comparison of performance to prior reports, both Claims Service Provider and Scheme level (trending)
- Progress of issues in Genie and on the PMR will be included

Quarterly Snapshot

- A quarterly view of QA findings will be prepared by the icare QA team with tracking of continuous improvement observations, recommendations, and action status. Quarterly reports are developed in consultation with the icare operational teams.

4.5 Roles and Responsibilities

Leadership and Commitment

The Workers Compensation Claims Leadership Teams ensure that the requirements of the QAF, including objectives and associated guidelines/policies, are consistent with the strategic context and direction of icare.

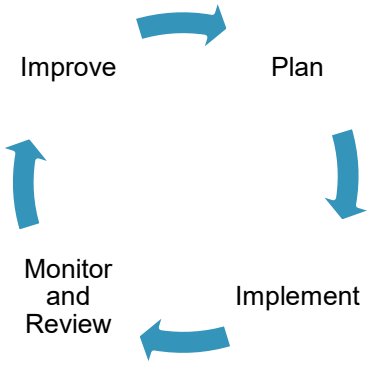
Roles and Responsibilities in relation to QAF

Title	Responsibility
Workers Compensation Claims Leadership Team (across Nominal Insurer and Treasury Managed Fund)	Overall accountability for the delivery of the Quality Assurance Program. Embed appropriate claims management into the operating activities of their respective areas of responsibility. Monitor Performance of icare and Claims Service Providers through the Quality Assurance Framework. Manage poor performance through appropriate governance forums/meetings/tools.
Compliance, Assurance and First Line Risk (CAR) Team	Provide assurance to the Workers Compensation Claims Leadership Teams through testing of claims management activities detailed in the Quality Assurance Framework. Provide timely reporting of findings. Support the Workers Compensation Claims Leadership Teams to monitor performance through the Quality Assurance Framework. Support the Workers Compensation Claims Team to manage poor performance through appropriate governance forums/meetings/tools. Work with the Workers Compensation Claims Leadership Team to update the Quality Assurance Framework as appropriate.

Head of Quality Assurance	Develop, implement, and monitor Workers Compensation Claims quality assurance strategy in collaboration with Workers Compensation Claims Leadership Team. Oversee the Workers Compensation Claims quality assurance activities and programs. Provide advice to Workers Compensation Claims Leadership Team including facilitation of assurance workshops and leadership of relevant governance committees.
Assurance Lead	Provide direct support to the Head of Quality Assurance including the strategy, planning, management, and delivery of a range of quality assurance, reviews, and activities. Contribute to the design, monitoring, evaluation, and ongoing maturity of the Quality Assurance Framework. Drive implementation across the relevant icare teams and to Claims Service Providers.
icare Quality Assurance Specialists	Conduct QA reviews within the scope of the QA Framework and facilitate communication of feedback. Conduct targeted reviews as required. Monitor and report on performance. Participate in calibration activities to ensure alignment with Claims Service Providers.
Claims Service Providers	Responsible for implementing the Workers Compensation Claims QAF within their business. Conduct QA reviews within the scope of the QA Framework and facilitate communication of feedback. Participate in calibration activities to ensure alignment with icare QA Team. Provision of monthly reporting to icare. Monitoring and tracking of findings/actions to the point of resolution. Responsible and accountable for achieving and maintaining agreed KPIs/QA Targets. Responsible and accountable for developing any other assurance activity that support the overall objectives of the Workers Compensation legislation, regulation, and guidelines, SIRA Standards of Practice, SIRA Customer Service Principles, the icare Service Model and Service Expectations and relevant knowledge articles.

5. Governance

A consistent approach to QA activities, including review of the QA strategy, to drive controlled and continuous improvement in performance.



Plan

- Identify areas of focus (test elements to be regularly reviewed)
- Prioritise areas of focus
- Define monitoring requirements for process and outcome
- Define the sample

Implement

- The consistency of QA results is controlled through many touch points:
    - **Clearly defined QA criteria for each review** signed off at the GM level prior to any review commencing.
    - **Calibration of QA results**
    - **Tools/Resources** – ensuring suitably qualified QA team, with capacity to undertake the intended schedule of reviews. Development of appropriate tools, processes, and documentation to support reviews and the provision of feedback.
    - **Minimum Standards** – establish minimum standards to ensure consistency of approach in undertaking QA reviews. Minimum standards are subject to change in response to business needs.

Monitor and Review

- Review success against agreed performance criteria and consider any opportunities to learn/improve.
- Following each QA review, the Workers Compensation Claims Leadership Team and the Claims Service Provider are provided with both a summary report and detailed list of actions and findings. The Workers Compensation Claims Leadership Team and Claims Service Provider are responsible for reviewing, developing, and managing action plans to address findings/recommendations.
- Issues identified from QA reviews will be tracked in Genie for 3 months. If there has not been sufficient improvement in results over that 3 months, these issues may be escalated to the Performance Management Register (PMR).
- A quarterly view of the QA results from the routine QA reviews is provided to include trend analysis, progress with continuous improvement recommendations and any issues requiring escalation to the PMR.
- Any incidents identified during QA reviews, will be raised, and managed in Genie in line with the relevant Incident Management and Risk Management Policies.

Action Management

- QA Team to be included in performance and governance meetings with Claims Service Provider and icare Management to discuss and track the actions required to improve performance.

- Findings from QA reviews will be tracked and monitored for 3 months in Genie (icare's incident management system). After 3 months, systemic issues will be moved onto the PMR and managed as per the relevant Claims Management Agreement/Contract.
- Any system issue not being moved onto the PMR after 3 months will need to go through a formal risk acceptance process.
- Incidents identified as part of conducting QA reviews will be managed in line with the icare Incident Management Policy.

Attachment 3.03 Assurance Reviews

Background

This Attachment 3.03 (Assurance Reviews) outlines various review and assurance requirements to be undertaken by the Claims Service Provider each Calendar Year.

Subject to clause 46 (Records, inspections and audits) of the Contract Terms, icare (or icare's nominee) may, at any time, audit each obligation and requirement under the Contract.

Requirements

Under section 4.5(a)(viii) of Schedule 3 to the Contract, the Claims Service Provider will provide icare with a copy of its internal assurance plan.

Upon the Claims Service Provider's completion of any review or assurance requirement as per this Attachment or otherwise under the Contract, the Claims Service Provider must provide a report to icare within ten Business Days setting out any inefficiencies or deficiencies identified by the review or assurance requirement.

Contract Description of Obligation or Requirement	Reviews and assurance requirements to be undertaken by the Claims Service Provider
<u>Controls Framework Reviews</u>	
Attachment 3.04 (*Internal Controls Framework*)	
Section 4.1 – Claims	Six monthly, on the date to be advised by icare
Section 4.2 – General computer controls	Annual, on the date to be advised by icare
Section 4.3 – Disaster recovery and Business Continuity Plans	Annual, on the date to be advised by icare
Section 4.4 – Governance	Annual, on the date to be advised by icare
Section 4.5 – Risk management	Annual, on the date to be advised by icare
Section 4.6 – Quality assurance function	Annual, on the date to be advised by icare

Contract Description of Obligation or Requirement	Reviews and assurance requirements to be undertaken by the Claims Service Provider
Section 4.7 – Reporting to icare	Annual, on the date to be advised by icare
Section 4.8 – Deed of amendment, Notices of Change, Directions and Statements of Work	Annual, on the date to be advised by icare
Section 4.9 – Protection of Personal Information	Annual, on the date to be advised by icare
Section 4.10 – Engagement and management of Third Party Service Providers, Key Input Providers, Related Bodies Corporate and Subcontractors (“Entities”)	Annual, on the date to be advised by icare
Section 4.11 Data quality	Annual, on the date to be advised by icare
Section 4.12 Fraud management	Annual, on the date to be advised by icare
Section 5.1 Claim Master File changes (if applicable)	Annual, on the date to be advised by icare
Section 5.2 General computer controls (if applicable)	Annual, on the date to be advised by icare
Section 5.3 (Accounting and Financial Close) (if applicable)	Annual, on the date to be advised by icare
<u>Contract Specific Reviews</u>	
Contract Terms – clause 23.2 WH&S and Workers Compensation Legislation Compliance	Annual, on the date to be advised by icare
Assurance reviews of key obligations in Schedule 1 - Customer Engagement and Claims Management Services	
Section 1.1 End to end Claims Management Services	On request
Section 1.3 Services to Employers and Workers	On request

Contract Description of Obligation or Requirement	Reviews and assurance requirements to be undertaken by the Claims Service Provider
Section 1.6 Claims Estimation	On request
Section 1.7 Wage Reimbursements	On request
Section 1.8 Utilisation and management of Third Party Service Providers	On request
Section 1.14 Data accuracy and integrity	On request
Section 1.15 General requirements – information and Records management	On request
Section 4 Capability	
Section 4.1 General requirements	On request
Section 4.2 Competency of the Claims Service Provider and Personnel	On request
Section 4.3 Case Manager specific competencies	On request
Section 5 Claims experience standards	On request
Section 6 Customer experience measurement	On request
Section 7 Litigation policy	On request
Section 8 icare's Confidential Information	On request
Section 9 Fraud management	On request
Section 10 Complaints	On request
Other reviews and assurance requirements	
Schedule 3 (*Performance Management and Governance*),	On request

Contract Description of Obligation or Requirement	Reviews and assurance requirements to be undertaken by the Claims Service Provider
section 4.4 Quality Management Framework	

Attachment 3.04 Internal Controls Framework

TABLE OF CONTENTS

Overview

The Claims Service Provider is required to prepare a document in the form of this Attachment 3.04 (“Internal Controls Framework”) for icare to review.

icare may engage external auditors to provide an independent audit on whether the Claims Service Provider has adequate Internal Controls, including that those Internal Controls have been effectively designed and are operating effectively. The auditors may, to the extent that they deem appropriate, use the outcomes of these audits in forming an opinion on the annual financial return of the Claims Service Provider.

The NSW Audit Office also uses these Internal Control documents and opinions in forming an opinion on the Scheme’s financial report that is submitted to the NSW Treasury and tabled in parliament.

Taking into account the potential risk to icare’s operations and financial accounts, icare may determine the audits that will be conducted annually on a risk-based approach. Where a control is subject to adverse audit comment and icare considers this material, it will require a further audit of the control objective in the following year to ensure that rectifications are put in place and the control is now operating effectively.

Part 1 of this document contains:

1) the form of the annual opinion to be provided by the auditors on the Internal Controls;
2) obligations required to be met by the Claims Service Provider to ensure compliance with clause 23 of the Contract Terms when managing Claims;
3) the Internal Controls that are to be reviewed annually on a risk-based approach; and
4) for each control area:
    a) a brief process description and summary of the risk that is being addressed;
    b) the control objectives that need to be addressed;
    c) system controls implemented by icare (if any) that may assist the Claims Service Provider to achieve the control objectives (to be completed and updated by icare from time to time); and
    d) sections for the Claims Service Provider to specify the Internal Controls that they have in place to address the control objectives. The Internal Controls will vary by Claims Service Provider depending on their individual systems, procedures and workflows. The Claims Service Provider must consult with icare regarding any proposed additional Internal Controls or any amendments to existing Internal Controls.

Part 2 of this document is similar to Part 1 but is only required to the extent that a Claim is not managed by the Claims Service Provider on the Claims Technology Platform and the parties agree (via a Special Condition or otherwise) that Part 2 applies.

1. Statement by the Approved Auditor concerning Internal Controls

The statement by the Approved Auditor concerning the Internal Controls is to be based on the applicable Australian Auditing and Assurance Standards Board AUASB standard as per its engagement letter with icare.

2. Compliance obligations

The Claims Service Provider must demonstrate compliance with Laws, Regulatory Guidance and policies described in clause 23 of the Contract Terms through the Internal Controls framework implemented by the Claims Service Provider.

3. Internal Controls testing plan

icare will determine the annual test plan annually on a risk-based approach, based on the control objectives identified in section 4 of this Attachment 3.04 (“Internal Controls Framework”).

4. Part 1: Control objectives and procedures for Claims managed on the Claims Technology Platform

4.1 Claims

4.1.1 Claim lodgement, assessment and management

Process description:

The Claims Service Provider must lodge and assess all Claims, including ensuring completeness of minimum data required and within legislative timeframes, from when they are first received by the Claims Service Provider.

Risk	Control objective	System controls	Internal Controls in place to achieve control objectives
Claims processed outside of legislative timeframes	All Claims to be processed within legislative timeframes	• [redacted] • [redacted]	[ ]
Claims are registered against an invalid Policy	Validation of the existence of a valid Policy is undertaken before the Claims are processed	[redacted]	[ ]

Risk	Control objective	System controls	Internal Controls in place to achieve control objectives
		[redacted]	
Claims liability is accepted where outside of the Policy coverage period	All Claims submitted are recorded against the correct Policy, in the correct period and against the correct NSW Workers Compensation Industry Classification ("**WIC**") system issued by SIRA as part of the Workers Compensation Market Practice and Premiums Guidelines	[redacted]	[ ]

Risk	Control objective	System controls	Internal Controls in place to achieve control objectives
		[redacted]	
Claims not covered by terms of Policy are processed, including provisional liability	Only those valid Claims covered by the terms of the Policy are processed, including provisional liability	[redacted]	[ ]
Minimum required Claims data is incomplete as required by the	All Claims data is complete for minimum data required and are correctly coded in	[redacted]	[ ]

Risk	Control objective	System controls	Internal Controls in place to achieve control objectives
WH&S and Workers Compensation Legislation and Regulatory Guidance	accordance with the Worker Compensation Insurer Data Reporting Requirements ("**WCIDR**") available on SIRA's website (for example, Duty Status Code is correct)	[redacted]	
Lack of capability and capacity of staff to process payments	The management of Claims is supported by Claims Service Provider Personnel qualified and experienced in making Claims liability decisions and assessments Adequate resourcing in place to lodge and assess claims as per required legislative timeframes	[redacted]	[ ]

4.1.2 Payments to Workers and Employers and Third Party Service Providers

Process description:

Where required, the Claims Service Provider will pay the Worker or Employer directly for the cost of Wages, compensation for a permanent impairment and any reasonably necessary reimbursements. The payment amounts and timeframes are to be in line with legislation.

Where required, the Claims Service Provider will also make payments to Third Party Service Providers for services rendered. The payment amounts are to be in line with gazetted fees (if applicable) and within legislative timeframes.

Risk	Control objective	System controls	Internal Controls in place to achieve control objectives
Incorrect, invalid or incomplete payments are made	Payments are only made for valid Claims that have been submitted and approved, in line with relevant legislation (for example, not declined) All Claims for payment for expenses, including travel, are valid, complete and accurate (as defined by the Workers Compensation legislation) Where income replacement payments are made to Workers, PAYG is correctly deducted (Where the Claims Service Provider does not utilise the Claims	[redacted]	[ ]

Risk	Control objective	System controls	Internal Controls in place to achieve control objectives
	Technology Platform, payments to the ATO on a weekly basis); Claims payments are processed within established Claims estimates Review of payments by an appropriately segregated second person is undertaken Before payment, invoices from Third Party Service Providers are validated where applicable, to the pre-approval of treatments (for example, physiotherapy) GST claimable from the ATO under Divisions 11 and 78 of the GST Act is accurately determined	[redacted]	

Risk	Control objective	System controls	Internal Controls in place to achieve control objectives
		[redacted]	

Risk	Control objective	System controls	Internal Controls in place to achieve control objectives
		[redacted]	

Risk	Control objective	System controls	Internal Controls in place to achieve control objectives
		[redacted]	
Lack of capability and capacity of staff to process payments	Payments for WID are supported by appropriate medical assessments and are determined by Claims Service Provider Personnel qualified and experienced in making such	[redacted]	[ ]

Risk	Control objective	System controls	Internal Controls in place to achieve control objectives
	assessments and are subject to review by another qualified person Adequate resourcing in place to process payments as per required legislative timeframes		
Duplicate payments are made	Overpayments / duplicate payments are identified and recouped from the recipient (where reasonable) An automated systems-based review of duplicate Claims is performed before payments are made to either Workers or Employers or Third Party Service Provider (preventative) that covers open, closed or reactivated Claims	[redacted]	[ ]

Risk	Control objective	System controls	Internal Controls in place to achieve control objectives
	Exception reports on duplicate payments are produced, reviewed and actioned		
Poor data / records management	Unauthorised changes cannot be made on the PPS file sent to Westpac or icare's nominated banker All payments are accurately recorded against established Claims and in the general ledger, in the correct period All payments are recorded against the correct payment code All payments are recorded against the correct payment code as detailed in the WCIDR	[redacted]	[ ]

Risk	Control objective	System controls	Internal Controls in place to achieve control objectives
	as available on SIRA's website Defined document management practices are implemented to ensure that information supplied by Workers, Third Party Service Providers and Employers is not required to be resubmitted	[redacted]	
Payments are not made in accordance with legislative timeframes	The calculation for the payments for worker entitlements comply with legislative requirements (including weekly Benefits, permanent impairments, WID and commutations) and relevant supporting documentation / information is maintained to support the calculation	[redacted]	[ ]

Risk	Control objective	System controls	Internal Controls in place to achieve control objectives
	Payments are approved in line with relevant legislative requirements, icare's guidelines, established authority limits and supporting documentation (such as medical certificates). All payments are made within legislative timeframes.	[redacted]	[ ]
	All invoices from Third Party Service Providers are aligned with the gazetted fees and if GST is applicable meet legislative requirements for a Tax Invoice	[redacted]	[ ]

Risk	Control objective	System controls	Internal Controls in place to achieve control objectives
Lack of segregation of duties	Duties within the Claims department are appropriately segregated to limit the risk of Fraud or error (for example, processing or calculation and payment) Review and approval of payments is performed by a segregated second person	[redacted]	[ ]

Risk	Control objective	System controls	Internal Controls in place to achieve control objectives
Process for when payments/cheques are returned is not adhered to	Returned payments (cheques and EFT) are allocated correctly and reasons for the return are independently investigated, validated and corrected Returned cheques are controlled physically and allocated correctly	[redacted]	[ ]
Unpresented cheques are not actioned	Unpresented cheques are reviewed and actioned Monitoring of unpresented cheques is undertaken	[redacted]	[ ]
Payments are not made within claims delegations	All payments are made in accordance with the Contract, including review of payments over $10,000 Claim payments are approved	[redacted]	[ ]

Risk	Control objective	System controls	Internal Controls in place to achieve control objectives
	according to established authority limits as defined in the Claims RACI	[redacted]	
Poor management and use of manual cheques	Manual cheques are only made for emergency payments to Workers and for amounts of less than $3,000. Blank manual cheques are adequately secured and accounted for Manual cheques are not used for payments to Third Party Service Providers	[redacted]	[ ]
Claims handover practices are not complete or followed	When the management of a Claim is moved between Case Managers,	[redacted]	[ ]

Risk	Control objective	System controls	Internal Controls in place to achieve control objectives
	a complete handover is completed to ensure that the management of the Claim, including services to the Worker, is not adversely impacted		
Services are not provided in accordance with legislative requirements	Services provided by Third Party Service Providers to Workers are in accordance with legislative requirements	[redacted]	[ ]
Fraud committed by Personnel or contingent workers who have access to internal systems and processes	The opportunity for Personnel to commit an act of Fraud is limited or not possible All identified Fraud is investigated in a timely manner and reported to icare within the defined format and timeframes Exception reporting is designed,	[redacted]	[ ]

Risk	Control objective	System controls	Internal Controls in place to achieve control objectives
	implemented, and reviewed to detect the occurrence of potential Fraud Detailed procedures for the management of all aspects of Suspect Activity and Fraud Case Managers who identify potential Fraud know what action to take. Clarity of roles and responsibilities between Case Managers, dedicated Fraud resources and icare		
Fraud committed by an external third party (including external service providers, claimants, and other external customers)	All Personnel receive training relevant to their role to identify red flags to detect and report the occurrence of potential Fraud All identified Fraud is investigated in a	[redacted]	[ ]

Risk	Control objective	System controls	Internal Controls in place to achieve control objectives
	timely manner and reported to icare within the defined format and timeframes Action is taken to recover funds where Fraud is confirmed Detailed procedures for the management of all aspects of Suspect Activity and Fraud; Case Managers who identify potential Fraud know what action to take. Clarity of roles and responsibilities between Case Managers, dedicated Fraud resources and icare Case Managers and dedicated Fraud resources know what the 'red flags' are that may indicate potential Fraud,		

Risk	Control objective	System controls	Internal Controls in place to achieve control objectives
	understand their role in identifying those red flags, and take appropriate action when they are identified		

4.1.3 Recoveries

Process description:

Where a Worker's Claim is covered by another type of insurance (for example, public liability, Compulsory Third Party ("**CTP**")), the Claims Service Provider will recover the cost of the compensation from the insurer, either progressively during the period of the Worker's Claim, or once the full amount of the Worker's Claim has been paid out.

Risk	Control objective	Internal Controls in place to achieve control objectives
Recoveries are not identified or actioned	All Claims are identified and actioned where a recovery from another insurer or third party may be made, within 21 days of receiving the Claim Recoveries are actioned for all Claims that are flagged as recoverable The complete amount is recovered from the other insurer. Recoveries are made progressively on at least a Quarterly basis as opposed to when the Claim is finalised	[ ]

Risk	Control objective	Internal Controls in place to achieve control objectives
Poor data management	Estimates of the recovery amount are correctly entered and monitored	[ ]
Poor management when conflict arises	A clear resolution pathway exists for dealing with Conflict e.g. the insurer is part of the same corporate group as the Claims Service Provider, including disclosure to icare	[ ]
Lack of delegations of authority in place	Delegations are in place for determining and approving when a recovery should no longer be pursued	[ ]

4.1.4 Resource management

Process description:

The Claims Service Provider will ensure that Claims are managed by capable and adequate resourcing.

Risk	Control objective	Internal Controls in place to achieve control objectives
Staff not having appropriate training and capability	Claims Service Provider Personnel are qualified and experienced in managing Claims. Capability of staff is reviewed and action is taken to address any gaps.	[ ]

Risk	Control objective	Internal Controls in place to achieve control objectives
Inadequate resourcing to handle the Claims volumes	Adequate resourcing in place to manage Claims. Resourcing levels are monitored and action is taken where the potential impact to the management of the Scheme portfolio.	[ ]
Lack of up to date process guides for team members to follow	Detailed process guides for the management of all aspects of Claims Management. Changes to process guides are identified, made and communicated to staff.	[ ]
Inability to recruit and retain FTE	Addressing resourcing gaps is not delayed. Adequate resourcing in place to manage Claims.	[ ]
Not managing poor performance of staff members	Performance of staff is monitored and action is taken to address any issues.	[ ]

4.2 General computer controls

Process description:

The Claims Service Provider's IT environment, which includes hardware, software and business processes that support the processing, storage and transmission of Data to deliver business objectives as outlined in the Contract, needs to be regularly tested to ensure icare and its Data is secure and protected from any loss or damage. General computer controls testing is required in the data centre and network operations, information security and system change control areas as detailed in the Contract.

Risk	Control objective	Internal Controls in place to achieve control objectives
Claims Service Provider's IT systems are unavailable due to external attack, resulting in failure to deliver business objectives.	System software, applications and operating systems are actively managed to remove vulnerabilities and remain up to date.	[ ]
Claims Service Provider's IT systems are unavailable due to external attack, resulting in failure to deliver business objectives.	System software and operating system configurations are baselined, managed and change controlled.	[ ]
Claims Service Provider's IT systems are unavailable due to external attack resulting in failure to deliver business objectives.	IT systems networks are designed and managed to limit the effects of any denial-of-service event.	[ ]
Claims Service Provider's IT systems are unavailable due to external attack resulting failure to deliver business objectives.	Systems and network are monitored for malicious activity, with established response and reporting processes.	[ ]
Data or privacy breach due to internal attack or action.	Data is managed to provide assurance that icare data remains complete, accurate, and valid throughout the update and storage process.	[ ]

Risk	Control objective	Internal Controls in place to achieve control objectives
Supply chain or third party failure.	Suppliers to Claims Service Provider's systems, applications and operations are monitored and managed regarding their control environments, in line with their materiality to the provision of service as it relates to icare.	[ ]

4.3 Disaster recovery and Business Continuity Plans

Process description:

In the case of a disaster or event which affects the continuity of the Claims Service Provider's business, plans should be in place to ensure that the Claims Service Provider can continue operations and that no significant Data is lost and services to Workers, Third Party Service Providers and Employers are not adversely impacted.

Risk	Control objective	Internal Controls in place to achieve control objectives
The Claims Service Provider's organisation cannot meet the agreed icare Maximum Acceptable Outage (MAO) requirements.	Management performs periodic and scheduled backup restore testing of key Data and systems relating to the Claims Service Provider's operations of the icare's managed service. Management tests the disaster recovery and Business Continuity Plan recovery strategies regularly to monitor and improve their effectiveness (at a minimum annually).	[ ]

Risk	Control objective	Internal Controls in place to achieve control objectives
Issues or unplanned instances where services were offline are not reported within agreed timeframes.	Management regularly reports issues, outages or unplanned instances where services outages impact to icare (in line with agreed timeframes) along with documented mitigations and action plans.	[ ]
Business continuity and disaster recovery testing is not completed within agreed timeframes.	Management reviews and refreshes disaster recovery and Business Continuity Plans / procedures where there is a material event or a material change to business operations and structure.	[ ]
Inadequate business continuity, disaster recovery and crisis management planning.	Management has a crisis management, disaster recovery and Business Continuity Plans that align to icare's requirements. Management documents disaster recovery and Business Continuity Plans covering the ongoing delivery of Services and align to icare's requirements.	[ ]

4.4 Governance

Process description:

Governance is a framework to support risk management practices and drive organisational behaviour, by providing clearly defined accountabilities, expectations and reporting requirements for all relevant parties.

Risk	Control objective	Internal Controls in place to achieve control objectives
Inadequate governance framework	Formal job descriptions are in place and stipulate the degree to which individuals must exercise judgment, outline delegations and are subject to supervision. Employees throughout the entity are assigned authority and responsibility related to their specific job functions.	[ ]
The organisation's objectives and expectations are unclear or not communicated.	Entity level business objectives and expectations are established, documented, and communicated within the business, and to icare, with respect to icare, NSW business and the organisation's operations as a Claims Service Provider. Management should also make sure that communication of these business objectives is provided on a regular basis, and not only as a one-time activity.	[ ]
Undesirable organisational behaviour.	Management maintains codes of conduct and other policies regarding acceptable business practices, conflicts, or expected standards of ethical and moral behaviour. These policies are regularly reviewed and / or updated in response to any material events or adverse findings and are regularly communicated to icare. All resources are required to complete mandatory training within agreed timeframes for	[ ]

Risk	Control objective	Internal Controls in place to achieve control objectives
	policies and keep up to date with required retraining schedules. Relationships with all third parties periodically reviewed (period to be agreed with icare) to ensure the entity maintains associations only with accredited (where required) and reputable third parties.	
Inadequate planning, monitoring or execution of business practices.	The board of directors (and icare) are informed in a timely manner (timeframe to be agreed with icare) of Significant issues that are identified through business activities, audits and / or through any anonymous reporting channels. Reporting relationships are established to facilitate the flow of information to appropriate people in a timely manner.	[ ]

4.5 Risk management

Process description:

The risk management process is used to identify potential and current risks throughout the organisation and determine appropriate mitigation strategies to achieve a level of risk acceptable to icare, the organisation and to the Scheme.

Risk	Control objective	Internal Controls in place to achieve control objectives
Inadequate identification, assessment, management, and	Management has an approved risk management framework and / or policy that aligns with	[ ]

Risk	Control objective	Internal Controls in place to achieve control objectives
monitoring of organisation and Scheme risks.	icare's risk management framework and policy. The framework and / or policy has established practices for the identification, assessment, management, and monitoring of organisational and Scheme risks (both financial and non-financial). Management should: • ensure that all employees are fully informed about the risk management framework and / or policy and ensure that this risk management framework and / or policy is implemented throughout the organisation and is consistently adhered to by all employees; • make sure that information about the risk management framework and / or policy is provided on a regular basis, and not only as a one-time activity; • ensure newly recruited resources are always informed about the risk management framework and / or policy in their first 30 days; • take action in response to violations of the risk management framework and / or policy; and	

Risk	Control objective	Internal Controls in place to achieve control objectives
	• review the risk management framework and / or policy on an annual basis, or more frequently if there are significant changes to organisation's or Scheme's structure or operations. Identifying risks includes estimating the significance of the risks identified, assessing the likelihood and impact of the risks occurring, and determining the need for mitigating action(s). Management considers the entire organisation as well as its extended relationships, such as Third Party Service Providers, in its risk assessment process, as well as the impact of its risks on icare. Management anticipates, identifies, and reacts to changes that affect its risks and icare's risks (including those risks delivered by changes undertaken by the organisation and emerging risks, including cyber and climate-related risks). Management identifies risks outside of its, and icare's, risk appetite, takes action to bring to risks back within appetite and provides early warning of potential risks outside of	

Risk	Control objective	Internal Controls in place to achieve control objectives
	appetite to icare in line with agreed Quality Measures. Management regularly reports risks, incidents, issues and / or adverse findings both internally (including to senior / executive management) and to icare (in line with agreed Performance Measures) along with documentation of associated control improvements, mitigations and / or action plans.	
Inadequate / ineffective controls and / or risk mitigation strategies (including controls assurance) are established.	Management designs, implements, and operates effective control activities to mitigate all identified risks. Management tests and monitors the design and operating effectiveness of all control activities on a regular basis (at least once every three years and more frequently for key controls). Management has designed controls to identify, detect and / or prevent instances of Fraud (both internal and external) and to adequately manage all identified risks of Fraud. Controls and mitigations prevent concentration risks due to reliance on certain third parties or core individual Personnel.	[ ]

4.6 Quality assurance function

Process description:

The quality assurance ("**QA**") and internal audit ("**IA**") functions provide management and the board of directors with a level of assurance over the quality of services being provided and the Internal Control environment governing key business processes.

Risk	Control objective	Internal Controls in place to achieve control objectives
Issues with quality are not identified.	The QA and IA function's scope, responsibilities, and audit plans are sufficient to evidence compliance with the Contract, relevant legislation, regulation, guidelines and standards. The QA function's scope, responsibilities and activities are aligned with Attachment 3.02 (*Workers Compensation Schemes Claims Quality Assurance Framework*) to support compliance with requirements. The QA and IA function focuses on key risks to both the Claims Service Provider and icare. The QA and IA functions, scopes and audit plans address the Claims Service Provider's and icare's key Scheme governance, risk and compliance obligations and requirements as described in the Contract.	[ ]
Issues with quality are not appropriately reported.	Regular reporting of issues and findings to icare, action plans are implemented and	[ ]

Risk	Control objective	Internal Controls in place to achieve control objectives
	evaluated and there is follow-up to verify implementation. Reporting of the QA and IA function's progress and results both internally (all levels within the organisation) and to icare.	
QA and IA functions are not competent or appropriately objective	The scope of the QA and IA function's activities are endorsed in advance with appropriate levels of management, the audit committee, and the independent auditors. The QA and IA plan is reviewed by the Claims Service Provider, regularly endorsed and is responsive to the Claims Service Provider's risk assessment. The independence QA and IA function is always maintained separately from the activities they assure.	[ ]
Issues with quality are not appropriately addressed to resolution through the continuous improvement cycle.	Regular reporting of issues and findings to icare, action plans are implemented and evaluated and there is follow-up to verify implementation. Reporting of the QA and IA function's progress and results both internally (all levels within the organisation) and to icare.	[ ]

4.7 Reporting to icare

Process description:

The Claims Service Provider is required to provide reports to icare, outside of the standard Operational Measures reporting on a periodic or ad hoc basis.

Risk	Control objective	Internal Controls in place to achieve control objectives
Incomplete/inaccurate reporting to icare and SIRA.	Milestones of reports due dates is maintained and checks undertaken to ensure milestones are met.	[ ]
	Appropriate approval and validation are undertaken before reporting is provided to icare.	[ ]
	Underlying reports used to report to icare are reviewed for accuracy and completeness.	[ ]
	Where the Claims Service Provider manages Claims with a system other than the Claims Technology Platform: • financial management reports as specified in the Financial Reporting Manual are provided from the financial management system in a consistent, accurate and timely manner; and • CDR reconciliations of cost of Claims are provided monthly that accurately explain differences in the amounts included in the CDR submission file and	[ ]

	those in the financial returns on a year to date basis.	
	Where the Claims Service Provider manages Claims with a system other than the Claims Technology Platform, data provided to the SIRA Corporate Data Repository (CDR) is checked for accuracy and completeness before being sent	[ ]

4.8 Deeds of amendment, Notices of Change, Directions and Statements of Work

Process Description:

The Claims Service Provider is required to implement variations (including under deeds of amendment, Delivery Proposals, Notices of Change and Statements of Work) to the Contract and comply with requests issued by icare.

Risk	Control objective	Internal Controls in place to achieve control objectives
The Claims Service Provider will not comply with the requirements of the Contract as updated from time to time.	Appropriate procedures are in place for the administration of variations and requests issued under the Contract.	[ ]
	Appropriate procedures are in place for reviewing and preparing costs for Statements of Work and Delivery Proposals.	[ ]

Risk	Control objective	Internal Controls in place to achieve control objectives
	Implementation is undertaken accurately and within the timeframe specified.	[ ]
	Procedures are in place to identify non-conformances and report them to icare.	[ ]

4.9 Protection of Personal Information

Process description:

The Claims Service Provider is responsible for ensuring that it, its Related Body Corporates, Key Input Providers or Subcontractors ("**Associated Entities**") providing any part of the Services complies with the relevant obligations under the Contract, State Privacy Laws and other relevant privacy obligations.

Risk	Control objective	Internal Controls in place to achieve control objectives
Non-compliance by the Claims Service Provider or its Associated Entities providing the Services with information and privacy laws, including State Privacy Laws including relating to information leaving NSW, Australian taxation Laws relating to tax file numbers and banking laws/agreements with the Scheme's banker.	The Claims Service Provider and its Associated Entities providing the Services must have procedures and systems in place that: • continually assess and confirm compliance with information and privacy Laws, including State Privacy Laws; • enable icare to comply with information and privacy Laws, including State Privacy Laws; • meet the requirements of any State or Territory legislation, cabinet administrative instructions or State Government standards relating to the State Privacy Laws; • meet the requirements of the GIPA Act; and • meet the requirements of the *Privacy Act 1988* (Cth) relating to tax file numbers.	[ ]

A complainant who is not satisfied with the outcome of an internal review conducted by icare under section 53 of the *Privacy and Personal Protection Information Act 1998* (NSW) ("**PPIP Act**"), may apply to the NSW Civil and Administrative Tribunal for an external review. The NSW Civil and Administrative Tribunal may make orders including an order to pay damages not exceeding $40,000.	The Claims Service Provider has and must confirm its Associated Entities have: • a Complaint / enquiry procedure in place that complies with Schedule 3 (Performance Management and Governance) and Schedule 8 (Information Management and Security) with respect to privacy Complaints relating to the Contract to manage matters referred in relation to the State Privacy Laws and other relevant privacy obligations of the Claims Service Provider and its Associated Entities providing the Services; • a mechanism for recording all Complaints or possible breaches and breaches of the State Privacy Laws (or other privacy obligation) that meets the requirements of the Contract and Law; • mechanisms in place to report all information and privacy breaches to icare, including Near Misses that indicate a weakness in controls; • appropriate procedures in place to investigate all Near Misses indicating a weakness in controls, alleged and actual breaches of NSW Information Protection Principles (as set out in the *Privacy and*	[ ]

	Personal Information Protection Act 1998 (NSW)), NSW Health Privacy Principles (as set out in the *Health Records and Information Privacy Act 2002 (NSW)*) and other relevant privacy obligations; • mechanisms to monitor and assess the achievement of compliance with all applicable information and privacy laws and the Contract by all its Associated Entities providing the Services; and • has processes in place to conduct ongoing review of procedures and policies to confirm they reflect any recommendations of the NSW Information and Privacy Commissioner (or any other applicable Government Agency).	

Lack of capability of staff to ensure compliance with privacy obligations	The Claims Service Provider must confirm that: • all Claims Service Provider Personnel and its Associated Entities providing the Services receive regular training in relation to its privacy obligations under the Contract; and • confidentiality agreements are signed and obtained prior to disclosing Personal Information. The Claims Service Provider and its Associated Entities must undertake a review each time a privacy breach or Near Miss occurs to determine the cause and confirm procedures are in place to reduce risk of reoccurrence; and The Claims Service Provider and its Associated Entities must regularly review its privacy policies and procedures when changes to the Law occur, and at least every two years.	[ ]

4.10 Engagement and management of Third-Party Service Providers, Key Input Providers, Related Bodies Corporate and Subcontractors ("Entities")

Risk	Control objective	Internal Controls in place to achieve control objectives
Processes for appointment and management of Entities will not meet the requirements of the Contract.	Claims Service Provider identifies when it is required to undertake a competitive open tender process that is: • for all goods and services that are valued over the EPP Threshold in Third Party SP Payments; or • where the Claims Service Provider intends to engage a Related Body Corporate or Key Input Provider. The Claims Service Provider: • includes a relevant review process that ensures that the procurement process is competitive, fair and transparent, represents value for money, ensures probity is maintained and complies with any Directions; • has appropriate delegation for approval of appointment of all Entities; and • details and records the information to be provided to icare upon appointment of an Entity that is evidence of qualifications, competencies permit, training by Entities.	[ ]

Risk	Control objective	Internal Controls in place to achieve control objectives
Entities are ineffective in providing the services and services do not align with the Scheme objectives.	The Claims Service Provider: • manages the records of all Entities, the details of the agreement, review dates and performance review results and communication with the Entities; • undertakes regular reviews of Entities; • measures the quality, cost, effectiveness of the services and ensures they align to the Scheme objectives; and • has performance management strategies for non-performing Entities.	[ ]
The Claims Service Provider does not comply with procurement requirements when engaging Entities.	Written agreements with Entities meet the requirements of clause 28 of the Contract; Has detailed policies and procedures in place in relation to procurement that meet the requirements of clause 28 of the Contract; The Claims Service Provider obtains icare's Approval when required in a timely manner and does not commence services with the Entity until the Approval is granted. The Claims Service Provider provides Personnel with the relevant training on the requirements to facilitate compliance.	[ ]

Risk	Control objective	Internal Controls in place to achieve control objectives
The Entities do not comply with the requirements of ISO 27001.	The Claims Service Provider ensures that the Entities comply with requirements of ISO 27001 and maintain compliance.	[ ]

4.11 Data quality

Process description:

The icare Data quality framework allows for monitoring of data quality submitted to icare and ingested into icare's Data warehouse. The framework allows for monitored rules and the processes by which icare Data stewards interact with Claims Service Providers and other partners as required for remediation of issues.

Risk	Control objective	Internal Controls in place to achieve control objectives
Non-compliance with defined standards, legislative requirements, and guidelines.	Compliance with the standards, legislative requirements and guide as defined in Schedule 8 – section 3.1.	[ ]
Data collection processes are not robust.	Ensure appropriate Data collection processes are in place that allow for the timely, accurate, and complete collection and submission of Data.	[ ]
Poor monitoring of Data quality (the key dimensions of Data quality are completeness, consistency, uniqueness,	Monitor data quality to ensure data is being captured consistently, accurately and completely and comply with the Data quality checks that icare performs.	[ ]

Risk	Control objective	Internal Controls in place to achieve control objectives
validity, accuracy, and timeliness).		
Corrections to Data are not reported to icare in a timely basis.	Ensure that any incorrect Data is amended and resubmitted to icare.	[ ]
Data collected is not fit for use for the delivery of Services.	Implement controls to ensure the accurate translation of information to Data, to support the delivery of Services.	[ ]
Data requested by icare is not timely, accurate or complete.	Provide all Data requested by icare within reasonably required timeframes.	[ ]
	Ensure Data submitted to icare meets the requirements detailed by icare, including all relevant fields, and complies with the relevant Manuals and applicable Laws.	[ ]

4.12 Fraud management

Process Description:

The Claims Service Provider must have in place a Fraud Risk Management Model that provides a proactive approach to the prevention and early, consistent and accurate identification and investigation of actual or suspected Fraud.

Risk	Control objective	Internal Controls in place to achieve control objectives
Poor process for reporting suspected Fraud matters to the dedicated Fraud resource	The internal reporting mechanism to the dedicated Fraud resource of Suspect Activity and Fraud is timely, accurate and complete.	[ ]
Measures are not in place to prevent and detect the occurrence of potential Fraud.	All staff receive training (approved by icare) relevant to their role to identify red flags to prevent, detect and report the occurrence of potential Fraud in a timely basis. Exception reporting is designed, implemented, and reviewed to detect the occurrence of potential Fraud in a timely manner.	[ ]
No response to identified potential Fraud.	All identified Fraud is investigated in a timely manner and reported to icare within the defined format and timeframes.	[ ]

Risk	Control objective	Internal Controls in place to achieve control objectives
Losses from Fraud or alleged Fraud are not recovered.	Recoveries and remediation from identified Fraud or alleged Fraud are identified and actioned in a timely basis.	[ ]
Poor investigation quality and/or not fit for purpose.	Investigation outcomes meet the relevant authorities (e.g. SIRA, NSW Police) requirements and are complete, timely and accurate.	[ ]

5. Part 2: Control objectives and procedures for Claims not managed on the Claims Technology Platform

These Internal Controls are only required to the extent that a Claim is not managed by the Claims Service Provider on the Claims Technology Platform.

5.1 Claim Master File changes

Process description:

The claims master file maintains all details of the Claims, including the pay-to details ("**Claims Master File**"). Regular maintenance is required to ensure that the Claims Master File is up to date and accurate.

Risk	Control objective	Internal Controls in place to achieve control objectives
Invalid or incorrect changes are made to the Claims Master File	The Claims Master File is accurate and current Only valid changes are made to the Claims Master File	[ ]

Risk	Control objective	Internal Controls in place to achieve control objectives
	All changes to the Claims Master File are input and processed accurately and completely	
Delegations for changes to the Claims Master File are not adhered to	All changes to the Claims Master File have been approved within established delegations	[ ]
Poor oversight of audit log of changes to the Claims Master File to ensure the completeness, accuracy and valid changes against the authorised change requests	Unmodifiable systems logs with sufficient detail of the change are maintained for all changes to the Claims Master File including who made the change, when the change was made, who approved the change and when the approval was made	[ ]
Lack of segregation of duties	Incompatible activities are segregated (for example, processing Claims and changing the Claims Master File) including additional approval and review required for all high risk information changes, that may impact payments or related communications (such as static items e.g. bank account, phone number, postal addresses and email address)	[ ]

5.2 General computer controls

Process description:

The Claims Service Provider's IT environment, which includes hardware, software and business processes that support the processing, storage and transmission of Data to deliver business objectives as outlined in the Contract, needs to be regularly tested to ensure icare and its Data is secure and protected from any loss or damage. General computer controls testing is required in the data centre and network operations, information security and system change control areas as detailed in the Contract.

Risk	**Control objective**	**Internal Controls in place to achieve control objectives**
Process breakdown.	Operations are managed to support the scheduling, execution, monitoring, and continuity processes for the complete, accurate, and valid processing and recording of financial transactions.	[ ]
Claims Service Provider's IT systems are unavailable due to external attack, resulting in failure to deliver business objectives.	Facilities are appropriately managed to protect the confidentiality, availability and integrity of icare information as it is utilised by the relevant components of the information technology infrastructure.	[ ]
Supply chain or third party failure.	Programs and systems are appropriately acquired or developed to provide platforms supporting the accurate, complete, and valid processing and recording of financial information.	[ ]
Data or privacy breach due to internal attack or action.	Data is maintained in a form such that it is retrievable, readable and understandable for the period defined by icare.	[ ]
Data or privacy breach due to	There is an effective segregation of IT duties in place including identification of potential Conflicts,	[ ]

Risk	Control objective	Internal Controls in place to achieve control objectives
internal attack or action	removal of access when Personnel leaves the Claims Service Provider employment, mechanisms to ensure that Conflicts do not arise and regular ongoing reviews of system access to icare's, the Employer's and Claims Service Provider's systems to ensure appropriate access limitations remain in place and compliance with the relevant Laws. Access requirements (including the removal) should be communicated to icare within the period defined by icare.	

5.3 Accounting and Financial Close

Process description:

The Claims Service Provider must provide monthly management reports, and when required, commentary for key variances. This also includes providing information to assist the preparation of icare financial statements and to ensure that audit is completed on time.

At the end of the accounting month, a number of controls and activities must be undertaken to ensure that the results presented in the financial statements are reliable and accurate.

Risk	Control objective	Internal Controls in place to achieve control objectives
Incorrect financial statements and incorrect information supplied to icare for Scheme	• Each sub-ledger is regularly reconciled to the general ledger, and exceptions identified are resolved and recorded in the general ledger in the appropriate accounting	[ ]

Risk	Control objective	Internal Controls in place to achieve control objectives
valuations and determination of remuneration.	period and maintain monthly profit and loss and balance sheet reconciliations; • Reconciliations for all significant accounts are performed properly, prepared on a timely basis, and independently reviewed. Issues identified are resolved and recorded in the general ledger on a timely basis; • Minimise the risk of Fraud by undertaking regular and timely reviews of bank statements; • Manage the cashflow and arrange funding from icare to ensure sufficient funds are available to make payments; • Bank reconciliations are prepared monthly, subject to independent review, and all reconciling items are appropriately identified and resolved; • All required analyses are prepared accurately and consistently in accordance with the Claims Service Provider's defined closing process and in the appropriate accounting period. Necessary adjustments and all related journal entries are identified and documented during the period-end accounting close process; • Ensure that all legal and taxation requirements are	

Risk	Control objective	Internal Controls in place to achieve control objectives
	complied with including for GST and PAYG; • Ensure that the amount of receipts and payments in the Revenue Accounts and Payment Accounts by type agree with the amounts included on the regular financial reports required to be supplied to icare as described in the Financial Reporting Manual; • A financial management system is used that completely, accurately and in a timely manner records transactions, assets and liabilities managed on behalf of icare, and where required agrees with the Claims Service Provider's Claims; • BAS returns are reconciled to Claims systems; and • PAYG payments are sourced from Claims systems and payments summaries are provided in accordance with legislative requirements.	

Attachment 3.05 Reports Matrix

TABLE OF CONTENTS

1. Reports Matrix

1.1 Monthly performance and portfolio reports

Description	Frequency/Due Date
Performance report* A report detailing the Claims Service Provider's progress and commentary against: (a) the Claims Service Provider's performance against Operational Measures, Quality Measures and Outcome Measures (where the performance is to be self-reported on a monthly basis); (b) the Claim Service Provider's progress or performance against such other performance indicators as icare may determine from time to time in its absolute discretion; and (c) any other matters that icare may reasonably require and notify to the Claims Service Provider. The Claims Service Provider must provide the performance reports in a format and with the level of detail determined by icare, or, in the absence of a format or level of detail determined by icare, in a form or level of detail agreed to by icare. As part of the Performance report, and otherwise on request from icare, the Claims Service Provider must provide up to date data and information on staffing numbers, capability movements and turnover, average case load numbers per case manager, organised by claim types and segments.	Monthly On the 5th Business Day of each month, commencing for a month nominated by icare
Performance Management Register update* The Claims Service Provider must provide updates on its progress with regards to the items requiring performance management activities as captured in the Performance Management Register. This is to include evidence as relevant to each item.	Monthly On the fifth Business Day after receipt from icare of the Performance Management Register
Complaints Report* The Claims Service Provider must provide icare with a report in the format prescribed by icare, that includes: (i) Level 1 Complaints resolved by the Claims Service Provider; (ii) written warnings provided to complainants relating to their behaviour; and	Monthly On the fifth Business Day of each month

Description	Frequency/Due Date
(iii) the implementation of new restrictions or changes to restrictions to a customer's access to the Claims Service Provider to manage behaviour and ongoing contact.	
Fraud Management Progress Report* The Claims Service Provider is to provide icare with progress reports of all open Suspect Activity and Fraud investigations using the form provided by icare from time to time.	Monthly On the fifth Business Day of each month
Privacy Incident Report* The Claims Service Provider is to provide icare a list of all Personal Information Security Incidents for the preceding month, which includes the date notified to icare and actions taken to address.	Monthly On the 5th Business Day of each month
Quality Assurance Framework* Terms of reference for the Claims Service Provider's Quality Assurance Framework report are to be in accordance with the requirements of Attachment 3.02 ("Workers Compensation Schemes Claims Quality Assurance Framework").	Monthly On the tenth Business Day of each month
Cyber Security Report* The Claims Service Provider is to provide a report containing metrics relevant to its cybersecurity stance as required by icare from time to time, with the initial metrics to consist of the following: (a) Coverage (Percentage) - Users enrolled in MFA (b) Coverage (Percentage) - Endpoint Detection & Response tooling (c) Percentage - Phishing click rate of users (d) Percentage - Phishing reporting rate of users (e) A list of offboarded staff in the reporting period (f) Mean Time to Remediate (MTTR) CVSS > 8.0 vulnerabilities on user workstations	Monthly On the 5th Business Day of each month or as otherwise specified by icare
Estimated claims paid and received figures for the Month and Year To Date (for non-Guidewire claims)	Monthly On the 2nd Business Day of each month

Description	Frequency/Due Date
The Claims Service Provider is to provide to icare an estimation of the monthly and Year- To Date claims paid and received amounts.	
Monthly financial returns (for non-Guidewire claims) The Claims Service Provider is to provide icare with a monthly financial return, consisting of a preliminary financial return and a signed monthly financial return.	Monthly Preliminary financial return - On the 4th Business Day of each month Monthly financial return – On the 14th Calendar Day of each month
Reconciliation of financial return to the Corporate Data Repository (for non-Guidewire claims) The Claims Service Provider is to provide a reconciliation of Claims expenses as per the financial return to the Corporate Data Repository.	Monthly On the 14th Calendar Day of each month
Monthly Claims Data submissions (for non-Guidewire claims) The Claims Service Provider is required to submit Claims Data: (i) to the Corporate Data Repository; and (ii) to icare once adjusted for any errors identified by SIRA.	Monthly (i) On the 5th Business Day of each month (ii) On the 10th Business Day of each month
Business Activity Statement return (for non-Guidewire claims) The Claims Service Provider is to provide icare with the required information for completion of Business Activity Statements for the Claims Service Provider GST Branch two Business Days prior to the due date for submission of the BAS to the ATO.	Monthly 2 Business Days prior to BAS submission due date

1.2 Quarterly, bi-annual and annual performance and portfolio reports

Description	Frequency/Due Date
Fraud Management Quarterly Performance and Portfolio Report	Quarterly

Description	Frequency/Due Date
The Claims Service Provider is to provide icare with a report outlining its final investigation outcome for Suspect Activity and Fraud investigations using the form provided by icare from time to time.	On the 10th Business Day after the end of each Quarter
Privacy Management Report The Claims Service Provider is to provide icare with a report outlining its privacy management activity including: - themes and insights from Personal Information Security Incidents in the preceding quarter; - actions and controls being put in place to minimise the risk of Personal Information Security Incidents occurring; and - progress against privacy related actions.	Quarterly On the 10th Business Day after the end of each Quarter
Privacy Attestations and Reports The Claims Service Provider is to provide icare with attestations and reports confirming completion of privacy training at induction and on a periodic basis, as required by clause 37.1(b)(v) of the Contract Terms.	Quarterly On the 10th Business Day after the end of each Quarter
Internal Audit Reports If the Claims Service Provider undertakes or is required to undertake additional internal audits not identified in its Internal Assurance Plan, in relation to the Services provided, the Claims Service Provider is to provide icare with a copy of the terms of reference and report and associated data for each internal audit undertaken.	Quarterly Within ten Business Days of the completion of the audit
Business Plan Progress report The Claims Service Provider is to provide a quarterly progress report against each of the plans and initiatives detailed within its Annual Business Plan	Quarterly On the 10th Business Day after the end of the Quarter
Competencies and Skills Progress Report The Claims Service Provider is to complete a competency assessment using the standardised scoring methodologies and tools to be provided by icare, and report the results to icare. The Claims Service Provider is to provide a progression report on the competencies and skills of staff, including the following:	Every six months, following the completion of the Baseline Assessment Report On the date to be advised by icare

Description	Frequency/Due Date
(a) percentage of staff at required proficiency level for their functional role as outlined by the Professional Standards Framework, (b) staff progress at moving into deeper understanding; (c) percentage of staff enrolled in and/or completed professional development courses or vocational education; and (d) the training provided and the percentage of staff that attended, completed, and is still to complete the training (summarised by role).	
Yearly financial return (for non-Guidewire claims) The Claims Service Provider is to provide icare with a yearly financial return.	Yearly 31 July

1.3 Ad hoc performance and portfolio reports

Description	Frequency/Due Date
Baseline Assessment Report Following the Claims Service Provider's completion of the baseline competency assessment outlined in section 4.2 of Schedule 1, the Claims Service Provider must provide to icare a report that demonstrates the results of that assessment, in a form and including the content required by icare.	Once, within 12 months of the Commencement Date Upon icare's request
Reports from Internal Assurance Plan The Claims Service Provider is to provide a report and associated data for each review undertaken.	Within 10 Business Days of the completion of the assurance activity

1.4 Annual strategic reports

Description	Frequency/Due Date	Contract Reference
Key Input Provider Register The Claims Service Provider must provide icare with an updated Key Input Provider Register.	Annual On or before 1 November or such other date specified by icare	Contract Terms, clause 30.3

Description	Frequency/Due Date	Contract Reference
ISO 27001 Certification, audits and applicable remedial reports	Annual On or before 1 April	Contract Terms clause 55.5(c)
Operational Risk Management The Claims Service Provider must: (a) develop and update a Business Continuity Plan and provide it to icare; and (b) conduct annual business continuity and disaster recovery testing and report to icare on the results of those tests.	Annual On or before 1 April	Contract Terms clause 56.1
Risk Management, Fraud Identification and Information Security The Claims Service Provider must conduct annual testing of risk management policies, Fraud Risk Management Model, and information security management and report to icare on the results of those tests.	Annual On or before 1 April	Contract Terms clause 56.2(b)
Claims Service Provider Declaration The Claims Service Provider must provide to icare a declaration, in the form of Schedule 6 (“Claims Service Provider Declaration”).	Annual On or before 31 July in each Year	Contract Terms clause 56.5; Schedule 6
Disengagement Plan The Claims Service Provider must provide its updated Disengagement Plan for icare's Approval.	(a) Annual, on or prior to 1 April; (b) at any time as required by icare; (c) on any occasion where there is a substantial change to:	Contract Terms clause 60.3

Description	Frequency/Due Date	Contract Reference
	(i) the Contract; or (ii) the volume of Claims or Services managed by the Claims Service Provider; (d) six months prior to the end of the Initial Contract Term and any Extension Period exercised in accordance with the terms of the Contract; and (e) if the Contract is terminated in accordance with clause 59.1.	
Competencies and Skills Annual Report The Claims Service Provider will provide a final assessment that details the percentage of staff at the required proficiency level for their functional role.	Annual, following the completion of the baseline competency assessment outlined in Schedule 1, section 4.2 On the date to be advised by icare	Schedule 1, section 4.2 (“Customer Engagement and Claims Services”)
Injury Management Program The Claims Service Provider will submit a copy of its Injury Management Program as revised from time to time to icare.	Annual On or before 1 April	Schedule 1, section 1.11(a) (“Customer Engagement and Claims Services”)
Internal assurance plan The Claims Service Provider must provide icare a copy of the Claims	Annual As set out in section 4.4(b) of Schedule 3,	Schedule 3, section 4.4(b) (“Performance

Description	Frequency/Due Date	Contract Reference
Service Provider's internal assurance plan.	unless another date is stipulated by icare.	Management and Governance") Attachment 3.03 ("Assurance Reviews")
Draft Annual Business Plan The Claims Service Provider must provide icare a draft annual business plan annually which is to include the minimum content requirements set out in section 3.3 of Schedule 3.	Annual As set out in section 3.3 of Schedule 3.	Schedule 3, section 3.3 ("Performance Management and Governance")
Records Management Program The Claims Service Provider is to provide its records management procedures which address how it creates, collects, keeps, stores and destroys Records in accordance with its Records Management Program.	Annual On or before 1 April	Schedule 8, section 1.2 ("Information Security and Management")
Destruction List – Records The Claims Service Provider is to provide a list of all physical Records that have been destroyed in the previous calendar year.	Annual On or before 1 April	Schedule 8, section 1.4(d) ("Information Security and Management")
Privacy Management Plan The Claims Service Provider must submit an annual Privacy Management Plan in accordance with the requirements in section 2.2 of Schedule 8.	Annual On or before 1 April	Schedule 8, section 2.2 ("Information Security and Management")
Custody Transfer List – Records The Claims Service Provider is to provide a summary of physical Claims Records for Claims that it has closed in the previous calendar year and wishes to transfer to the control and custody of icare.	Annual On or before 1 April	N/A

Description	Frequency/Due Date	Contract Reference
Details of Claims File Holdings Where control and custody of physical Claims Records are to be transferred to icare, the Claims Service Provider is to provide a detailed list of information for such Records to be deposited with icare's storage provider.	Annual On or before 1 April	N/A

Schedule 4 Project Services Framework

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Schedule 4

Project Services Framework

Table of contents

Overview

Format

This Schedule 4 (*Project Services Framework*) provides the framework for the management of proposed Project Services. This Schedule 4 (*Project Services Framework*) is intended to ensure the Claims Service Provider and icare have a robust project management methodology for the request, approval, implementation and management of a proposed Project Service.

Glossary

Capitalised terms used in this Schedule 4 (*Project Services Framework*) have the meaning set out in the Dictionary.

1. Project Services Request

1.1 Requirements

(a) If icare wants the Claims Service Provider to perform services in respect of a Project (including in circumstances where the Claims Service Provider proposes provision of a Project), icare must make a request to the Claims Service Provider in writing.

(b) icare will:

(i) include a draft Statement of Work for review by the Claims Service Provider; or

(ii) outline the requirements of the proposed Project Service, in its Project Services Request.

1.2 Response to Project Services Request

(a) Within ten Business Days after receiving a Project Services Request, or within another period agreed by the parties, the Claims Service Provider must provide a response in writing to icare.

(b) In the response, the Claims Service Provider will:

(i) where the Project Services Request is accompanied by a draft Statement of Work:

(A) confirm that the Claims Service Provider will provide the proposed Project Services on the terms of the draft Statement of Work; or

(B) advise icare of any proposed changes to the draft Statement of Work; or

(ii) where the Project Services Request is not accompanied by a draft Statement of Work, include a draft Statement of Work with its response setting out the terms on which the Claims Service Provider proposes to provide the proposed Project Services requested by icare.

1.3 Negotiation

(a) Within ten Business Days after receiving the Claims Service Provider's Project Services Response, or such longer period as icare requires, icare will give the Claims Service Provider a written notice:

(i) accepting the Project Services Response, in which case icare will provide the final Statement of Work for the parties to execute;

(ii) proposing amendments to the Statement of Work; or

(iii) rejecting the Project Services Response.

This notice may be provided through provision of an updated and/or final Statement of Work for execution.

(b) Where agreement is not reached within ten Business Days (or such other period as the parties agree) after the Claims Service Provider receives icare's notice under section 1.3(a), icare may issue a final Statement of Work to the Claims Service Provider, which is then binding on the parties as a Statement of Work from the date of receipt unless the Claims Service Provider issues a notice of objection within five Business Days of receipt of the final Statement of Work.

1.4 Escalation

If the Claims Service Provider issues a notice of objection to icare in accordance with section 1.3(b):

(a) the parties will attempt to reach agreement on the terms of the Statement of Work in accordance with the process described in clause 57.2(b) to clause 57.2(d) of the Contract as if the issue were a Contract Dispute and had not been resolved by the icare Partnering and Performance Manager and the Claims Service Provider Partnering and Performance Manager within the timeframe contemplated in clause 57.2(b);

(b) icare may withdraw the Statement of Work issued under section 1.3(b), and the parties will continue to comply with the obligations under the Contract; and

(c) if icare does not withdraw the Statement of Work and the parties subsequently reach agreement on the terms of the Statement of Work, the parties will execute the agreed Statement of Work for the provision of the Project Services.

1.5 Effect

Where a Statement of Work is binding on the parties under section 1.3(b), or has been executed by the parties, then:

(a) the Statement of Work forms part of this Contract; and

(b) the Claims Service Provider will provide the Project Services on the terms of this Contract.

1.6 Material Regulatory Changes and Material Directions

This section 1 will not apply in respect of Projects, Project Services or Statements of Work the subject of a Material Regulatory Change or Material Direction contemplated under Section J of this Contract.

2. Verification of Costs for Project Services

The parties agree that:

(a) the terms of Section J of the Contract (and not section 2(b) of this Schedule) determine the Claims Service Provider's entitlement to charge, and icare's obligation to pay, for Project Services performed under Statements of Work that are raised under Section J of the Contract;

(b) in respect of Project Services requested or proposed under clause 11 of the Contract, unless otherwise expressly stated in a Statement of Work:

(i) the amount payable for the performance of a Project Service (such amount being the "Chargeable Amount") will not exceed an amount equal to the lesser of:

(A) the amount icare reasonably believes would be the incremental Direct Costs incurred by an Other Claims Service Provider to perform the Project Service, operating at Best Industry Practice; and

(B) the actual incremental Direct Costs incurred by the Claims Service Provider to perform the Project Service; and

(ii) subject to section 2(b)(i), the Claims Service Provider will not be able to charge, and icare will not be required to pay, any amount for performance of a Project Service except:

(A) where the Chargeable Amount applicable to performance of the Project Service is determined to exceed $100,000, in which case the Claims Service Provider will be entitled to charge the Chargeable Amount in full; or

(B) where the Chargeable Amounts applicable to performance of Project Services:

(1) that are performed and completed in the same Financial Year; and

(2) for which the Claims Service Provider is not entitled to charge due to the application of paragraph 2(b)(ii)(A),

are determined in aggregate to exceed $250,000, in which case the Claims Service Provider will only be entitled to charge the amount by which those Chargeable Amounts are determined in aggregate to exceed $250,000.

(c) the Claims Service Provider must demonstrate to icare's reasonable satisfaction how the incremental Direct Costs of performing a Project Service have been incurred and calculated; and

(d) icare may require that the actual incremental Direct Costs to the Claims Service Provider of performing a Project Service be determined by an independent auditor appointed or Approved by icare having regard to Australian industry standards.

3. Project Plan

3.1 Project Plan Content

(a) The parties agree that:

(i) each Statement of Work must contain the minimum requirements of a Project Plan set out below:

(ii) icare may require

(A) that:

(1) the Project Plan content forms part of the Statement of Work, without the need for a separate Project Plan; or

(2) a separate Project Plan be completed by the Claims Service Provider for Approval by icare; and

(B) that Attachment 4.02 (Project Plan Costing Template) be completed by the Claims Service Provider for Approval by icare; and

(iii) where a separate Project Plan is required, once the Project Plan has been Approved it will form part of the Statement of Work.

(b) The minimum requirements of a Project Plan are as follows:

(i) Objective(s)

Provide an overview of the objectives and planned outcomes of the proposed Project Service.

The objectives should include reference to the intended benefits of the proposed Project Services and how these will be measured, including how the delivery of the proposed Project Services will impact on customer outcomes or experience.

(ii) Scope

Outline the scope of the proposed Project Service, including areas in and out of scope and define the scope to ensure the scale of the proposed Project Service is clearly outlined and understood. Areas deemed outside the scope of the proposed Project Service must be clearly expressed and justified to ensure overall scope is clearly documented and understood.

(iii) Project Governance

Define the roles and responsibilities ensuring that all roles have been accounted for and the Personnel accountable for delivery are defined. Outline the roles associated with the proposed Project Service, the responsibilities associated with each role and the Personnel assigned to each role, as well as describing how project governance ensures delivery of the proposed Project Service.

If the proposed Project Service has an impact on icare's IT systems, the governance and Milestones applicable to the proposed Project Service must be clearly detailed in the Project Plan provided to icare for Approval.

(iv) Dependencies

Outline any dependencies that a proposed Project Service has on:

(A) internal and external parties, including Third Party Service Providers, Workers, Employers, Subcontractors, Service Companies; and

(B) other Project Services being provided by the Claims Service Provider.

Provide a description of the nature of the dependency and the primary contact.

(v) Assumptions

Outline any assumptions that have been used to devise the content of the Project Plan.

(vi) Milestones

Provide a summary in the Project Plan of the Milestones, Critical Milestones and Final Critical Milestones and planned dates for the delivery of the proposed Project Service.

(vii) Deliverables

Outline all key Deliverables of the proposed Project Service including the measures against which the Deliverables will be Accepted by icare.

(viii) Stakeholders

Identify all stakeholders associated with the proposed Project Service (including, but not limited to Third Party Service Providers, Workers, Employers, Subcontractors and Service Companies).

(ix) Communication

Outline the communication approach to be adopted for the proposed Project Service.

(x) Risks

Outline known risks associated with the delivery of the proposed Project Service and the Claims Service Provider's approach to risk management for the lifecycle of the proposed Project Service, including:

(A) risks to delivery of the proposed Project Service; and

(B) any operational risks that may arise from delivering the proposed Project Service.

(xi) Issues

Outline known issues associated with the delivery of the proposed Project Service and the Claims Service Provider's approach to issue management for the lifecycle of the proposed Project Service.

(xii) Testing

Outline Acceptance Criteria, and the approach to be taken to testing and Acceptance of the proposed Project Service and Deliverables.

(xiii) Change Management

Outline the Claims Service Provider's approach to change management for the proposed Project Service.

(xiv) Project Reporting

Outline the Claims Service Provider's approach and frequency of reporting against Deliverables, issues and risk management for the proposed Project Service.

3.2 Project Plan Documents

The Claims Service Provider must, at icare's request, include one or more of the following documents in a Project Plan:

(a) Project management plan;

(b) Project schedule;

(c) Business/technical design;

(d) Test plan;

(e) Risk management plan;

(f) Cost benefit analysis;

(g) Issue management plan;

(h) Business change program;

(i) System change program;

(j) Business handover program; and

(k) Evaluation/post implementation plan detailing stages and criteria upon which the proposed Project Service will be completed and delivered to the appropriate standard.

3.3 Project Costs

(a) icare's contribution towards the costs of the proposed Project Service will be determined in accordance with the Contract. The Claims Service Provider must not exceed the hourly rates provided in Attachment 4.01 (*Project Plan Approved Maximum Rates*) to this Schedule 4 (*Project Services Framework*).

(b) The Claims Service Provider will not be entitled to charge for the cost of responding to a Project Services Request.

(c) Where the Claims Service Provider submits a Project Services Request, the Claims Service Provider is to submit its projected incremental Direct Costs using the template provided in Attachment 4.02 (*Project Plan Costing Template*), unless otherwise agreed with icare.

(d) The roles and associated rates listed in Table 1 of Attachment 4.01 (*Project Plan Approved Maximum Rates*) relate only to roles located within Australia. If there is necessity to utilise roles that are located outside Australia, or that are not defined in Attachment 4.01 (*Project Plan Approved Maximum Rates*), the Claims Service Provider should provide icare with details of the required roles and icare will determine if these roles and rates are Approved.

4. Attachments

Attachment 4.01 (*Project Plan Approved Maximum Rates*)

Attachment 4.02 (*Project Plan Costing Template*)

Attachment 4.03 (*Statement of Work*)

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Attachment 4.01 Project Plan Approved Maximum Rates

The Claims Service Provider may request icare's approval of changes to the rates in Table 1 during the Term. The rates may be amended at the discretion of icare.

Table 1

Project Service Resources	$ Per Hour Permanent Staff *	$ Per Hour Contractors **
Project Management		
Program Manager	$ [redacted]	$ [redacted]
Project Manager	$	$
Project Administrator	$	$
Technical		
Database Manager	$	$
Solution Architect	$	$
Systems Engineer	$	$
Network Engineer	$	$
Security/Governance/Delivery Specialist	$	$
Applications Developer	$	$
Database Administrator	$	$
Tester	$	$
Change Management		
Change Management Consultant	$ [redacted]	$ [redacted]
Business Analyst	$	$
Trainers		
Corporate trainer	$ [redacted]	$ [redacted]
Claims Personnel		

Claims Team Leader	$ [redacted]	$ [redacted]
Technical Specialist	$	$
Case Manager	$	$
Administrative		
Business Support Administration	$ [redacted]	$ [redacted]
Incidentals		
Materials, freight, travel, accommodation***	At cost	At cost

***** **Rates are inclusive of overheads and exclusive of GST**

****** **Rates are inclusive of on costs, super, WC, payroll tax, agency margins and GST**

******* **Requires prior Approval from icare before expenditure and will not be Approved for payment without presentation of valid tax invoice**

The roles and associated rates listed in Table 1 relate only to roles located within Australia. If there is a necessity to utilise roles that are located outside Australia, or that are not defined in Table 1, then section 3.3(d) of Schedule 4 will apply.

Annually, the above rates are to be indexed in accordance with the movement in the Average Weekly Earnings index between 2023 and Calendar Year (n). This will be determined by dividing the Seasonally Adjusted Average Weekly Earnings index published by the Australian Bureau of Statistics for “Earnings; Persons; Full Time; Adult; Ordinary time earnings; New South Wales” at May of Calendar Year (n) by the equivalent index at May 2023. Where that information is not published or not available, icare will select a suitable equivalent index or estimate of wage inflation in New South Wales.

For clarity, the index used was 1790.00 at May 2022.

For example, if the index at May 2023 was 1800.00 and the index at May 2024 was 1854.00 then the AWE for 2024 would be 1.03.

For example, if the index at May 2023 was 1800.00 and the index at May 2025 was 1917.00 then the AWE for 2025 would be 1.065.

Attachment 4.02 Project Plan Costing Template

Table 1

Project Services Costing Template					
This template is a guide only and it is not expected that all categories will be applicable to all Project Services.					
1. Information Technology (IT) Costings					
Category	**Design/ Development Hours**	**Development Costs**	**UAT (System & Testing) Hours**	**UAT (System & Testing) Costs**	**Total IT Costings**
	$ .00	$ .00	$ .00	$ .00	$ .00
	$ .00	$ .00	$ .00	$ .00	$ .00
	$ .00	$ .00	$ .00	$ .00	$ .00
	$ .00	$ .00	$ .00	$ .00	$ .00

	$ .00	$ .00	$ .00	$ .00	$ .00
	$ .00	$ .00	$ .00	$ .00	$ .00
	$ .00	$ .00	$ .00	$ .00	$ .00
	$ .00	$ .00	$ .00	$ .00	$ .00
Total per response to Draft Variation	$ .00	$ .00	$ .00	$ .00	$ .00

2. Operational Costings

Cost Category	Service Provider Cost	Activities included in Costing
Personnel Include costs associated with the implementation of operational activities/processes.	$ .00	
Communication Include costs associated with communications to manage the	$ .00	

implementation including items such as printing of letters, increased enquiries etc.		
Personnel Training Include costs associated with training of Personnel on new processes and procedures.	$ .00	
Total	$ .00	

3. Other Costings

All costs detailed in this section must be clearly detailed including supporting documentation.

<ITEM>	**Hours**	**Costs**	**Other**	**Other**	**Total**
		$ .00	$ .00	$ .00	$ .00
		$ .00	$ .00	$ .00	$ .00
		$ .00	$ .00	$ .00	$ .00
		$ .00	$ .00	$ .00	$ .00

Total		$ .00	$ .00	$ .00	$ .00
Total Project Costings					$ .00

Attachment 4.03 Statement of Work

1 Statement of Work

Project Services Title	
Project Services Number (to be allocated by icare)	
Contact Phone Number	
Date Project Request Raised	
Effective Date	
Claims Service Provider Response **(Accepted/not Accepted)**	

Objective(s)
Overview of the objectives and planned outcomes of the Project.

Implementation
Outline Implementation of the Project including due dates, Milestones, Deliverables and Acceptance Criteria.

Amount Payable
Agreed Costs icare's contribution towards project costs will be determined in accordance with the Contract.

Additional Notes
[Possible (but not exhaustive) drafting options for alternative IP ownership positions] ***Option 1: icare owns Project Material, but is prevented from licensing it to another CSP for an agreed period of time*** The parties agree that: • clause 33.1 will apply in respect of any Records and Foreground Material comprised in the Project Material; and • icare will not for a period of [ ] grant an Other Claims Service Provider a licence in respect of the Project Material provided under this Statement of Work (other than Records). ***Option 2: CSP owns Project Material (and is free to use) and licenses it to icare as part of Claims Service Provider Material for free use and sub-licensing*** The parties agree that: • notwithstanding clause 33.1, the Project Material (other than Records), and all Intellectual Property Rights in the Project Material (other than Records), are the

property of the Claims Service Provider, and will on creation vest in the Claims Service Provider;

- the Project Material (other than Records) will not be Foreground Material or icare Material, but rather will form part of Claims Service Provider Material; and
- the Claims Service Provider grants icare and any nominee of icare (including any person who exercises the functions of icare) an irrevocable, perpetual, world-wide, royalty-free and licence fee-free, non-exclusive licence (including the right to sublicense) to use, reproduce, adapt, modify and communicate Claims Service Provider Material relating to this Statement of Work for any purpose in connection with its business and functions.

Option 3: CSP owns Project Material (and is free to use) and licenses it as part of Claims Service Provider Material to icare (subject to an initial period in which icare cannot sub-license the Project Material to another CSP)

The parties agree that:

- notwithstanding clause 33.1, the Project Material (other than Records), and all Intellectual Property Rights in the Project Material (other than Records), are the property of the Claims Service Provider, and will on creation vest in the Claims Service Provider;
- the Project Material (other than Records) will not be Foreground Material or icare Material, but rather will form part of Claims Service Provider Material;
- the Claims Service Provider grants icare and any nominee of icare (including any person who exercises the functions of icare) an irrevocable, perpetual, world-wide, royalty free and licence fee-free, non-exclusive licence (including the right to sublicense) to use, reproduce, adapt, modify and communicate Claims Service Provider Material relating to this Statement of Work for any purpose in connection with its business and functions; and
- icare will not for a period of [ ] grant an Other Claims Service Provider a licence in respect of the Project Material provided under this Statement of Work (other than Records).

Attachments
List any attachments to this Order, including the Project Plan (if a separate attachment).

Execution

This Statement of Work is made in accordance with the Contract.

Approval Number: _____

SIGNED FOR AND ON BEHALF OF **Insurance and Care NSW** acting for and on behalf of the **Workers Compensation Nominal Insurer** (ABN 16 759 382 489) or by its duly authorised representative:	)	
	)	……
	)	icare Signature
	)	
	)	……
	)	Full Name of icare Authorised Representative
	)	
	)	……
	)	Title of icare Authorised Representative
	)	

Witness Signature

Print Full Name of Witness

Position

Date of Signature

Execution by the Claims Service Provider

SIGNED FOR AND ON BEHALF OF **THE CLAIMS SERVICE PROVIDER** by its duly authorised representative:	)	.....
	)	The Claims Service Provider's Signature
	)	.....
	)	Full Name of the Claims Service Provider's Authorised Representative
	)	.....
	)	Title of the Claims Service Provider's Authorised Representative

Witness Signature

Print Full Name of Witness

Position

Date of Signature

Schedule 5 Banking and Financial Management

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Schedule 5

Banking and Financial Management

Table of contents

Overview

This Schedule sets out the requirements for the provision of Banking and Financial Management Services.

In performing the Banking and Financial Management Services, the Claims Service Provider must comply with:

- Attachment 5.01 (*Banking Manual*); and
- Attachment 5.02 (*Taxation Manual*).

Format of this Schedule

The sections of this Schedule are as follows:

1. Scope of Services - this section describes the obligations of the Claims Service Provider regarding its performance of the Banking and Financial Management Services.
2. Core Competencies - this section identifies the core competencies that the Claims Service Provider must demonstrate when performing the Banking and Financial Management Services.

Glossary

Except where stated otherwise, capitalised terms used in this Schedule have the meaning set out in the Dictionary.

1. Scope of Services

In performing the Services, the Claims Service Provider:

(a) must only use the bank and banking accounts Approved by icare; and

(b) will only be liable for bank fees to the extent that they are not listed as a fee met by icare in Attachment 5.01 (*Banking Manual*).

1.1 Manage Payments

The Claims Service Provider must:

(a) ensure that all payments received on behalf of icare (including, without limitation, Employee excess and Claims recoveries) are deposited into the bank account associated with the Claims Technology Platform nominated by icare;

(b) ensure that all payments made on behalf of icare are made from the Claims Technology Platform or the bank account associated with the Claims Technology Platform nominated by icare;

(c) ensure payments are made only in accordance with the law and for:

  (i) Benefits to Workers;

  (ii) payments to Workers including reimbursements;

  (iii) Third Party Service Provider Payment;

  (iv) payments to the Australian Taxation Office, Centrelink, Medicare, and other statutory entities relating to activities managed by the Claims Service Provider on behalf of icare; or

  (v) any other purpose authorised in writing by icare;

(d) implement and regularly review the effectiveness of the Claims Service Provider's Internal Controls to ensure that errors and the potential for Fraud are eliminated, in accordance with Attachment 3.04 (*Internal Controls Framework*);

(e) notify icare of any potential or emerging issues that might impact compliance with this Schedule as soon as practicable; and

(f) provide to icare's auditors all necessary support to enable completion of icare's Financial Year end audit at 30 June each Financial Year.

2. Core Competencies

The core competencies for the provision of Banking and Financial Management Services are the requirements and standards in sections 2.1 to 2.5 below.

2.1 Claims Service Provider Personnel

The Claims Service Provider must ensure its Personnel who are engaged to provide Banking and Financial Management Services have minimal direct contact with Workers and Employers and other interested parties.

2.2 General

The Claims Service Provider must:

(a) develop, maintain and comply with a competency matrix that identifies required competencies for every level of Personnel across every business function related to the Claims Service Provider's performance of the Banking and Financial Management Services;

(b) for each position related to the Claims Service Provider's performance of the Banking and Financial Management Services, recruit Personnel with the appropriate competencies, as defined in the Claims Service Provider's competency matrix;

(c) ensure that the relevant Personnel are trained and competent in the Claims Service Provider relevant frameworks, models and methodologies required to perform the Banking and Financial Management Services;

(d) ensure that finance skills of relevant Personnel are kept up to date by ensuring that ongoing training is provided to retain and enhance skills to meet evolving business needs;

(e) apply a process of open and honest communication between employees and their managers about performance against defined capabilities and performance indicators promoting consistency, equity and transparency in the performance of the Banking and Financial Management Services; and

(f) plan for and review the workforce requirements of the Services to meet current and future organisational needs relating to the Banking and Financial Management Services.

2.3 Taxation Skill

The Claims Service Provider must engage Personnel that are qualified, skilled and experienced in:

(a) GST and PAYG tax compliance management for a large insurance business;

(b) the use of tripartite arrangements and their impact on the entitlement to claim Input Tax Credits;

(c) the treatment of GST for medical and health services; and

(d) understanding the application of the tax matters outlined in Attachment 5.02 (Taxation Manual), and can give the Claims Service Provider Personnel practical guidance on those tax matters.

2.4 Not Used

2.5 Banking Systems

The Claims Service Provider must engage Personnel that are skilled and experienced in the use and controls over the online banking system used by icare (including with the appropriate training and background material provided by icare where required).

3. Attachments

Attachment 5.01 (*Banking Manual*)

Attachment 5.02 (*Taxation Manual*)

Attachment 5.01 Banking Manual

TABLE OF CONTENTS

Overview

This Attachment outlines the banking arrangements provided for the Claims Service Provider and how they are required to operate these facilities.

This Attachment is relevant to the Claims Service Provider and its Personnel when they are:

(a) involved in receiving or making payments from icare bank accounts operated by the Claims Service Provider; or

(b) involved in the governance and reporting of these payments described in paragraph (a).

1. Introduction

The requirements of Banking and Financial Management Services are outlined in Schedule 5 (*Banking and Financial Management*) of the Contract. If there is any conflict or inconsistency between this Banking Manual and Schedule 5, then Schedule 5 prevails.

The key objectives of this Banking Manual are to ensure that the Claims Service Provider:

(a) uses the bank and bank accounts established by icare and interacts electronically with the bank regarding any recoveries, payments and reconciliation files; and

(b) ensures there are effective Internal Controls over recoveries and payments to reduce or eliminate the risk of potential errors and Fraud.

2. Scheme Banker and Banking Requirements

2.1 Scheme Banker

(a) As at the Commencement Date, Westpac Banking Corporation ("**Westpac**") is icare's banker and the Claims Service Provider must work cooperatively with Westpac in provision of the Services. If an alternative scheme banker is appointed, icare will notify the Claims Service Provider and the Claims Service Provider will comply with icare's instructions about the use of different banking facilities.

(b) icare is responsible for all transactional banking facilities such as the opening of all bank accounts and arranging additional banking product modules, such as a payment processing service.

2.2 Banking Services

The Claims Service Provider must pay from its own funds the costs of any testing required for integration with the banking facilities from Westpac, in relation to any changes to the Claim's Service Provider's systems that are not requested by icare.

2.3 Verifying Officers

(a) icare's Personnel are the only verifying officers on icare's bank account.

(b) All requests for access to Westpac's:

(i) Corporate Online System ("**COL**"); and

(ii) Payments Plus system,

must be made in writing to icare's General Manager, Financial Management and Treasury, or equivalent manager as required by icare.

3. Payments

3.1 All Payments to be made electronically

All payments must be made by Electronic Funds Transfer ("**EFT**") except if:

(a) it is not practicable to do so in the particular circumstances applying to the Worker; or

(b) the law requires payment in another manner.

3.2 Urgent Payments to Injured Workers

The preferred method of making an urgent payment to an injured Worker is to use the COL to directly transfer funds to that injured Worker's bank account.

3.3 International Payments

(a) The COL must be used for all international payments.

(b) Subject to section 3.3(c), the Claims Service Provider must ensure that if the Benefits to be paid to the injured Worker are set by law in Australian dollars that this is the currency that the payment is made in.

(c) Where Services are provided to injured Workers overseas and the provider requests payment in their local currency or a widely negotiable currency (such as Euros or US dollars), payments can be made in that currency using the COL (with any transaction expenses associated with the local currency conversion to be borne by the provider).

(d) The Claims Service Provider must ensure that appropriate controls are in place for any overseas payment. Any payment in foreign currency of more than the equivalent of AUD$100,000 must be advised in advance to icare in writing so that rates can be negotiated with Westpac.

(e) The payment details must be entered into the Claims Technology Platform at the time of payment.

3.4 Cheque Fraud

(a) While Payment Processing Service ("**PPS**") cheques use high security inks and paper, there have been cases of cheques being fraudulently amended. Fraud is easier to perform on manual cheques.

(b) Where Fraud on the PPS is detected, the Claims Service Provider must report the matter to the New South Wales police and obtain a NSW Police Report Event Number and the name and telephone number of

the officer the report was made to. In addition, as soon as practicable, the Claims Service Provider must lodge a claim on their company letterhead with Westpac detailing:

(i) a request for a full refund to be made;

(ii) information of any alterations to the cheque;

(iii) the full name of the original beneficiary (if it has been altered);

(iv) the address the cheque was mailed to;

(v) confirmation that the original beneficiary did not receive the cheque;

(vi) the official NSW Police Report Event Number; and

(vii) the name and telephone number of the police officer who took the report.

The claim must be signed by the Claims Service Provider Authorised Representative or a senior authorised representative of the Claims Service Provider.

(c) A copy of each claim lodgement letter must be forwarded to the Claims Service Provider mailbox at icare.

(d) Any replacement payment must be made by EFT.

(e) The parties acknowledge that the indemnity in clause 49.1 of the Contract Terms applies in respect of Fraud that occurs after a cheque (including a PPS cheque) is returned to the Claims Service Provider (including for the adding of additional documentation) if Westpac refuses to recompense icare for misappropriated funds.

3.5 Stopping a Cheque

Stop payments for PPS cheques through the Claims Technology Platform is to be undertaken through Payments Plus to ensure the enriched data is received into the CAMT053 (Statement) for ingestion by the Claims Technology Platform.

3.6 Unpresented Cheques

Subject to section 3.7(c), cheques that have been unpresented for more than 60 days will be dealt with in accordance with the *Cheques Act 1986* (Cth). Subject to applicable laws, Westpac will only reject a cheque if the drawer has made a stop payment direction.

3.7 Requirements

The Claims Service Provider must:

(a) issue a stop-payment to Westpac as soon as possible after becoming

aware that a cheque has been lost, stolen or destroyed;

(b) regularly review cheques, including bank cheques that have been unpresented for more than 60 days to ascertain why the cheques may not have been presented; and

(c) contact payees where a cheque with a value of more than AUD500 has not been presented for more than 60 days, to advise them that the cheque is unpresented, and request that they promptly bank the cheque. If the payee advises that the cheque has been lost, stolen or destroyed, the Claims Service Provider must complete a stop-payment advice to Westpac (to be processed through the Payments Plus system) and provide a replacement payment to the payee by EFT.

4. Westpac Corporate Online System

4.1 General

(a) The COL is to be used for urgent individual payments to overseas beneficiaries and service providers only, the details of which must be entered into the Claims Technology Platform immediately after payment.

(b) The Claims Service Provider is not to access icare's banking facilities from a COL system controlled by the Claims Service Provider. Rather each Claims Service Provider has been established as a separate COL "office" of icare. This has enabled icare to apply the following minimum governance requirements to its accounts:

(i) a person can only be either an "administrator", "authoriser" or "creator" in the COL. They cannot occupy more than one of these roles;

(ii) all administrative activities in the COL are controlled by icare's Personnel;

(iii) two authorisers are required to approve all payments;

(iv) as the COL is an internet based system, a person with a COL role can be based in any of the Claims Service Provider's Australian offices; and.

(v) the Claims Service Provider Authorised Representative is required to approve all persons who are to be designated as "creators" or "authorisers" in the COL and the functions they can access. All requests for new users must be accompanied by a completed 'Westpac Certified Customer Identification Document', including certified supporting documents. icare's General Manager, Financial Management and Treasury will

arrange for the documents to be processed into the COL and will return a completed application to the Claims Service Provider for the person designated as a “creator” or “authoriser” to sign. This form must be returned to icare’s General Manager, Financial Management and Treasury for submission to the bank.

(c) Additionally in the case of authorisers, the Claims Service Provider Authorised Representative is to also advise if the person is to be an authoriser and the financial limits that are to apply to that person including:

(i) payment daily limit (the maximum total value of online payments that can be made in a day); and

(ii) Payment Transaction limit for an online payment (the maximum amount of a payment that can be made).

(d) On an annual basis, icare will provide a listing of users of the COL and their access rights and require the Claims Service Provider to confirm that the user is still employed by the Claims Service Provider and their access rights and financial limits continue to be appropriate.

(e) Where the COL is unavailable due to system issues, icare must be advised immediately so that acceptable alternate file transmission procedures can be implemented.

4.2 COL Security Requirements

icare has determined that the governance principles applied to NSW government agencies (“**Principles**”) are an appropriate governance framework and accordingly have been adopted by icare.

These Principles are:

(a) enforce strict separation of duties between COL creators and approvers of payments. icare will incorporate this in its COL set up for the Claims Service Provider;

(b) users should have time limits placed on their access. User access for extended leave should also be suspended. All persons will only be allowed to access COL between 7:00am to 7:00pm Monday to Friday. If the Claims Service Provider considers access is needed outside of these hours Approval of icare is to be obtained. Administrators will be required to suspend a user when they are on more than five days’ leave;

(c) users should not access COL from offices other than those Approved by icare. The Claims Service Provider’s premises including offices of related companies are considered Approved sites to access icare’s

COL system. Homes of Personnel and other premises from which Personnel perform work for the Claims Service Provider are also Approved by icare, provided the Personnel are accessing COL by logging in from within the Claims Service Provider's VPN using equipment provided by the Claims Service Provider that has the same level of security as the Claim Service Provider's on-premises network. As part of the Claims Service Provider's regular communication to Personnel, users are to be advised that, subject to the above, they cannot access icare COL functionality from other premises;

(d) payment creators can only create payments to authorised vendors, Employers or injured Workers. Payment must only be made to such persons where the Claims Technology Platform holds the approved BSB and account number for electronic payments;

(e) mandatory use of token security within COL for payment authorisation. All authorisers of payments must use icare's COL token;

(f) create and enforce token management policy. The Claims Service Provider is required to ensure that tokens are stored by administrators or authorisers or (as applicable) in a secure location when not in use;

(g) passwords that are used in conjunction with the token are not to be written down;

(h) create and enforce policy on the payment authorisation process, with emphasis on payment and payment file validation. This should be multi-level and linked to segregation of duties;

(i) the Claims Service Provider must:

(i) have a person prepare a payment and two other persons authorise it; and

(ii) maintain payment limits within COL at the lowest practical level.

The Claims Service Provider's daily payment limit for payments made within COL is currently set at equivalent AUD$1 million. This amount meets normal needs with occasional need to adjust payment timing during payment peaks to ensure that the limit is not exceeded. In addition, individual payment authorisation limits apply to each payment authoriser based on advice from the Claims Service Provider Authorised Representative including:

(iii) total daily payment limits; and

(iv) Payment Transaction limits;

(j) users to check COL website digital certificate before proceeding, ensuring validity of the COL website and the encrypted connection. As part of the Claims Service Provider's regular communication to

Personnel on IT matters, the Claims Service Provider Authorised Representative must ensure Personnel are advised of these requirements;

(k) users to understand that all activity logging on COL is centralised, detailed and unmodifiable. As part of the Claims Service Provider's regular communication to Personnel on IT matters, the Claims Service Provider Authorised Representative must ensure Personnel are advised of these requirements; and

(l) conduct training of COL users that includes coverage of general PC security around phishing, recognition of secure sites and PC use policy (either as part of or in addition to any associated information security requirements set out in clause 55.4 of the Contract Terms and Schedule 8 (*Information Security & Management*).

The Claims Service Provider must ensure that these Principles are appropriately addressed in their general IT controls. These controls may be audited on a regular basis.

4.3 The Payments Plus System

(a) The Payments Plus system is to be used for stopping cheque payments and for reissuing remittance advices.

(b) The Claims Service Provider must only use Payment Plus for claims that it manages.

(c) The Claims Service Provider Authorised Representative is required to approve all persons who they wish to be creators or authorisers in the system ("**Uploaders**") and the functions they can access. All requests for new Uploaders should be accompanied by a completed 'User Establishment Form iLink/Payments Plus' and a 'Westpac Certified Customer Identification Document', including certified supporting documents and sent to icare for approval.

(d) On an annual basis icare will provide a listing of users of the system and their access rights and require the Claims Service Provider to confirm that the user is still employed by the Claims Service Provider and that the access rights continue to be appropriate.

(e) Where the Payments Plus system is unavailable due to system issues icare is to be advised immediately.

4.4 Return of PPS Cheques to the Claims Service Provider

(a) Cheques may be returned to the Claims Service Provider only where the cheque is to an organisation that requires the cheque to be attached to an application form, such as the NSW Police. To ensure appropriate Internal Controls, these cheques must be returned, processed and

dispatched by a department within the Claims Service Provider's organisation that is not the department that initially processed or approved the payment.

(b) The Claims Service Provider can have the PPS cheque addressed to the organisation of the Claims Service Provider referred to in section (a) above.

Attachment 5.02 Taxation Manual

TABLE OF CONTENTS

Overview

The Claims Service Provider operates under the GST and PAYG registration of the Workers Compensation Nominal Insurer (**WCNI**) for the Claims activities undertaken on behalf of icare. Only these activities are the subject of this Attachment.

This document is relevant to the Claims Service Provider Personnel involved in making payments from the Claims Technology Platform.

Introduction

In respect of transactions undertaken on behalf of WCNI, the Claims Service Provider must comply with Australian taxation laws in the same way as any other entity, and with other requirements of the laws that may apply to entities that make payments of Wages. These taxation obligations include the GST Law and obligations of a 'large withholder' under the *Taxation Administration Act 1953* (Cth).

The Claims Service Provider is expected to be informed about the legislative requirements and keep up-to-date with changing Australian Taxation Office (**ATO**) requirements and applicable ATO guidelines. This Manual is not taxation advice and does not exempt the Claims Service Provider from examining the applicable taxation guidelines and rulings to determine the treatment that should be adopted.

icare may inform the Claims Service Provider when it becomes aware of changes to ATO policies specifically relating to Workers Compensation.

GST Law applies to Workers Compensation insurance in the same way that it applies to general insurance.

1. GST Management

1.1 GST Registration

(a) An entity that has an annual GST turnover (as defined in the GST Act) at or above $75,000 (or $150,000 if the entity is a not-for-profit organisation) is required to register for GST. An entity with a lower turnover is also able to voluntarily register for GST.

(b) If an entity seeking to provide Services to icare or the Claims Service Provider does not appear to comply with the requirements in section 1.1(a) then the Claims Service Provider is required to remind the entity about complying with the requirements in section 1.1(a).

1.2 GST on Claims Payments

(a) The Claims Service Provider must be fully aware of the requirements under the GST Law. In particular, the Claims Service Provider needs to fully understand Divisions 11 and 78 of the GST Act and ATO GST rulings/determinations (including GSTR 2006/9 and GSTR 2006/10).

(b) WCNI can claim an Input Tax Credit (**ITC**) on the GST paid for goods and services provided in respect to a "Claim" under Division 11 of the GST Act when it:

(i) engages the supplier (in the context of this Contract, the supplier will typically be a Third Party Service Provider);

(ii) instructs the supplier about the supply;

(iii) enters into a contractual relationship with the supplier for the right to have the supply made and accepts liability to pay for the supply of the goods, services or anything else;

(iv) holds a valid Tax Invoice; and

(v) the supplier has made a taxable supply.

(c) The Claims Service Provider must ensure, when purchasing goods and services that are not input-taxed, that to the maximum extent possible, suppliers that are registered for GST purposes are engaged.

(d) Where an Employer is not entitled to fully claim the GST charged on premiums as an ITC, WCNI is, under Division 78 of the GST Act, entitled to claim a Decreasing Adjustment (**DA**) on Claim costs that do not constitute acquisitions (as defined) made by WCNI under Division 11 and relate to claim events that happened since the introduction of GST. A DA under Division 78 can be claimed irrespective of whether GST was charged on those costs (for example weekly Benefits).

1.3 GST on Recoveries

(a) Where WCNI receives recoveries or a “Claim excess” this is not consideration for making a supply (as defined in the GST Act), and accordingly is not subject to GST.

(b) In determining the amount to be recovered, the Claims Service Provider must consider the potential Increasing Adjustment effect under Division 78.

2. Taxation of Benefits – Including PAYG

2.1 Requirement to Withhold and Remit PAYG

The Claims Service Provider must comply with the requirements of the *Taxation Administration Act 1953* (Cth) (**PAYG Act**). Accordingly, pursuant to section 12-120 in Schedule 1 of the PAYG Act, the Claims Service Provider must withhold PAYG tax from Workers receiving Workers Compensation payments where required.

WCNI is a large withholder for purposes of the PAYG Act.

2.2 Tax File Number (TFN) Declarations

A TFN declaration is required to be completed by the Worker prior to receiving weekly Benefits. If a Worker chooses not to complete the TFN declaration, then the Claims Service Provider must withhold the top rate of tax plus the Medicare levy from all payments to the Worker.

Where the Worker has indicated in their TFN declaration that they have applied for a TFN, or enquired with the ATO about their existing TFN, and after 28 days they have not given their TFN, then the Claims Service Provider must withhold the top rate of tax plus the Medicare levy from all future payments to the Worker until such time as their TFN has been validly declared.

2.3 Uses of Tax File Numbers (TFNs)

The Claims Service Provider must have procedures in place regarding the collection of TFNs. The Claims Service Provider must be fully compliant with the *Privacy (Tax File Number) Rule 2015* (**Rule**) issued under section 17 of the *Privacy Act 1988* (Cth). That Rule regulates the collection, storage, use, disclosure, security and disposal of individuals' TFN information.

2.4 Payments to Dependants Including Children

Income received by minors is generally taxed at the highest marginal tax rate unless the income is excepted income. Taxation Determination TD92/133 outlines the treatment of weekly compensation to children of a deceased Worker under the *Commonwealth Employees Rehabilitation and Compensation Act 1988* (Cth). The Taxation Determination TD92/133 states that periodic payments made under other accident or compensation legislation to dependent children of deceased persons are also considered to be a pension and are excepted income for minors. Excepted income is taxed at ordinary tax rates.

Accordingly, the Claims Service Provider should ensure that all payments of weekly Benefits in respect of dependent children pursuant to sections 25, 26

and 31 of the 1987 Act are to be taxed at ordinary PAYG rates, rather than the higher penalty rates that can apply to other types of income of taxpayers under 18 years of age.

Non-resident minors who receive compensation payments will be taxed at the ordinary PAYG rates that apply to non-residents rather than the higher minor rates.

All non-residents do not have a tax-free threshold and do not pay Medicare levy.

Payments to dependants are subject to normal PAYG taxation requirements - including obtaining a TFN declaration for the dependant.

2.5 Treatment of Lump Sum Payments

Taxation Determination TD93/3 outlines that a payment that is a partial commutation of weekly compensation payments is assessable income, as the underlying Benefit (i.e. weekly compensation) was assessable income and its character has not changed by it being converted to a lump sum. However, payments received as redemption of any other of the Worker's rights under the 1987 Act are of a capital nature and so are not included in assessable income. Nor are these payments assessable under the capital gains provisions.

If the documentation supporting the commutation under section 87E of the 1987 Act specifically indicates the level of weekly payments of compensation included in the lump sum amount, that amount should be treated as assessable income of the Worker.

Other commuted amounts under Division 3, Part 3 of the 1987 Act (i.e. compensation for medical, hospital and rehabilitation expenses), or section 10 of the former Act, or where the commutation includes such sums but the level of these amounts and those relating to weekly payments of compensation are not shown separately, may be regarded as being in the nature of a capital payment and not assessable income.

2.6 Lump Sum Payments in Arrears

Lump sum payments in arrears include Workers Compensation weekly Benefits relating to prior financial years. While lump sum amounts are taxable in the year of receipt, a Worker may be entitled to a lump sum payments in arrears tax offset in respect of such payments when the ATO assesses the Worker's income taxation liability.

2.7 Overpayments of Workers Compensation Entitlements

Taxation Determination TD2008/9 outlines that amounts of Workers Compensation Benefits mistakenly paid to Workers that the Worker is

required to repay are not to be regarded as assessable income of that Worker. The Claims Service Provider must ensure the proper treatment of the repaid amount for PAYG payment summary and PAYG tax purposes – depending on whether the overpayment was identified in the same year as payment or in a later year.

However, should the debt subsequently be waived, then the ATO considers that there may be potential income tax implications. Such forgiven amounts are to be included in the assessable income of the Worker for PAYG purposes.

Schedule 6 Claims Service Provider Declaration

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Schedule 6

Claims Service Provider Declaration

Capitalised terms used in this declaration have the meaning given to them in the Contract dated _____ between _____ (the **Claims Service Provider**) and icare (**Contract**).

I,

_____

full name of person making declaration

_____

address of person making declaration

_____

position of person making declaration [Note: The Contract Terms provide that this must be the Chief Financial Officer of the Claims Service Provider or such other senior executive that icare may agree to making this declaration]

declare that, in all material respects:

1. I have personally reviewed the processes and systems in place to support the Claims Service Provider's compliance with the Contract. This includes the processes and systems in place to support the Claims Service Provider's compliance with the *Work Health and Safety Act 2011* (NSW) and the *Work Health and Safety Regulation 2017* (NSW).
2. Except to the extent set out in Attachment A, to the best of my knowledge and belief, after making all reasonable enquiries, the Claims Service Provider has complied with the requirements of the Contract (including compliance with all applicable laws) at all times from the Commencement Date to the date of this declaration.
3. Except to the extent set out in Attachment A, to the best of my knowledge and belief, having made such enquiries as I consider necessary for the purpose of appropriately informing myself, the following are true as at the date of this declaration:
    (a) All financial information has been provided by the Claims Service Provider in accordance with the requirements in the Contract and applicable Laws.
    (b) The Claims Service Provider has adhered to the Internal Controls reviewed by icare.
    (c) As part of the ongoing work between the Claims Service Provider and icare to establish the Internal Controls framework, reasonable steps have been taken, or are being taken, to implement adequate controls and procedures to ensure an effective system of Internal Controls operated over icare's transactions during the period 1 July to 30 June of the most recent Financial Year and to eliminate remediation and rework required.
    (d) The Claims Service Provider has satisfactorily resolved or has action plans to satisfactorily resolve all outstanding items identified in previous control audits.
    (e) To the extent that the Claims Service Provider is taking steps to implement adequate controls and procedures (see paragraph 3(c) above), or has action plans to resolve outstanding items (see paragraph 3(d) above), reasonable details of the steps and plans, and their status and scheduled completion dates as of the date of this declaration, are described in Attachment A.
    (f) The Claims Service Provider's Equipment and processes and those of any Service Company have successfully passed internal testing within the previous 12 months, or such other period as Approved by icare, as required by the Contract.
    (g) The Claims Service Provider and any Key Input Provider has obtained and maintained ISO 27001 certification, or higher standard of certification agreed to by icare, for the scope and locations Approved by icare, and covering all Services provided to icare and all the Personnel, systems and locations used to provide them, at all times since the

Commencement Date.

(h) The Claims Service Provider's Equipment and processes and those of any Service Company that is used to calculate the payment or collection of moneys has and will, in the absence of ad hoc error in data input, correctly calculated the amounts due or payable.

(i) Any payment, handling or collection of moneys by the Claims Service Provider and any Service Company complies with the requirements set out in the Contract and by Law.

(j) The Claims Service Provider has obtained written confirmation from any Third Party Service Provider procured by the Claims Service Provider and each Key Input Provider stating that the Third Party Service Provider and Key Input Provider has paid all due tax, required insurances and remuneration in the past financial year.

(k) The Claims Service Provider:

  (i) has a workplace health and safety committee in place that has clear oversight of the effectiveness of policy, procedures, work instructions and of its register of workplace health and safety risks;

  (ii) reports on existing and new workers compensation claims and the actions taken to return injured workers to work;

  (iii) has undertaken the necessary corrective actions identified as a result of incidents, audits or any other means;

  (iv) has in place a documented workplace rehabilitation policy; and

  (v) ensures its employees have completed any mandatory workplace health and safety training.

(l) The Claims Service Provider:

  (i) recognises that customer service conduct has an impact on outcomes for people that have made a claim for compensation or have purchased a Policy;

  (ii) has resources and skills in place to give effect to practices and a culture that supports the delivery of service in line with SIRA's Customer Service Conduct Principles;

  (iii) has a customer service framework (or equivalent) which aligns to SIRA's Customer Service Conduct Principles when dealing with Policyholders (where appropriate) and managing Claims; and

  (iv) has disclosed any and all Issues or inability to meet SIRA's Customer Service Conduct Principles to icare.

(m) The Claims Service Provider has conducted at least one business continuity and disaster recovery test and reported the results of the test to icare at least once during the preceding 12 months of the Contract.

(n) The Claims Service Provider has:

  (i) complied with the approved uses of the Relevant Fund in accordance with legislative requirements and the requirements of the Contract; and

  (ii) ensured that all monies that belong to the Relevant Fund have been properly accounted for in accordance with the provision of the Contract. The Claims Service Provider uses icare's Claims Technology Platform for all financial transactions.

(o) Any new:

  (i) member of the Claims Service Provider's board of directors;

  (ii) Chief Executive Officer of the Claims Service Provider; and

(iii) Claims Service Provider Authorised Representative,

who was appointed in the previous 12 months has completed a police/criminal history check.

Signature: _____

Declared at _____
place

in _____
State or Territory in which the declaration is made

the _____ day of _____ in the year _____
date on which the declaration is made

Annexure A

_____

Full name of person making declaration

_____

Address of person making declaration

_____

Name of Claims Service Provider

1. Non-compliance

I declare that, in respect of the statutory declaration made by me on [***insert day***] day of [***insert month and year***], the following circumstances of non-compliance existed or continue to exist:

(a) ***[Note: insert details of non-compliance here in reasonable detail, including dates and specific clause references to the Contract. The CSP should also describe the impact or likely impact of this non-compliance and explain what steps it has taken (or will take) to rectify the non-compliance.]***

2. Steps to implement adequate systems and procedures or action plans (Declaration, paragraph 3(e))

(a) ***[Note: Describe here any steps being taken by the Claims Service Provider to implement adequate systems and procedures, or implement action plans to resolve outstanding items. That information should be set out in reasonable detail, including their status and scheduled completion dates. See further paragraphs 3(c), 3(d) and 3(e) above.]***

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Schedule 7 Claims File Transfer

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Schedule 7
Claims File Transfer

Table of contents

1. Claims File Transfer

1.1 Purpose

This Schedule describes the required process for conducting a Claims File Transfer.

1.2 Scope

Open Claims and Closed Claims must be transferred in accordance with this Schedule, and will occur in one of the following ways, unless otherwise required by icare:

(a) the transfer of a single Claim within the Claims Technology Platform, to be completed as required by icare;

(b) the transfer of Claims within a cohort of Claims, to be completed as required by icare; or

(c) the transfer of Data, electronic documents and physical Records for Claims Files that are to be transferred to the Claims Technology Platform ("**Data Migration**"), which is to be undertaken in accordance with icare's Data Migration requirements as required by icare.

1.3 Objectives

This Schedule defines the responsibility of the Claims Service Provider and icare to ensure:

(a) a consistent process is applied to Claims File Transfers;

(b) there is minimal disruption in the delivery of Services to Workers and Employers;

(c) there is minimal disruption to the Scheme; and

(d) performance and Claim outcomes detailed under Schedule 3 (*Performance Management and Governance*) are maintained.

1.4 Contact person

The Claims Service Provider must nominate a person who will be responsible for the Claims File Transfer throughout the Transfer Period and Disengagement Period (if applicable). The contact details must be:

(a) provided to the Transfer Lead; and

(b) made available to Other Claims Service Providers involved with the Claims File Transfer.

The nominated person will be the primary contact for icare and Other Claims Service Providers in connection with the Claims File Transfer.

1.5 Transfer Plan

(a) The Claims Service Provider must work with the Transfer Lead to develop a transfer plan that supports the Claims File Transfer, and ensures compliance with all requirements of the Claims File Transfer under the Contract.

(b) The Transfer Lead will:

(i) provide details of selected Claims Files;

(ii) consult with the Claims Service Provider and Other Claims Service Providers; and

(iii) determine timeframes to develop an optimal transfer plan for each cohort.

1.6 Transfer Governance

The Claims Service Provider must report to icare as part of the Claims File Transfer. Reporting requirements will be determined as part of the transfer plan or as otherwise notified by the Transfer Lead. The reporting requirements may include:

(a) attending regular transfer working group meetings;

(b) providing regular status reporting;

(c) identifying and managing risks and issues related to the Claims File Transfer; and

(d) adequately managing and closing assigned actions.

Unless otherwise specified by icare, the Transfer Lead will confirm the Claims File Transfer through the Claims Technology Platform using information reported by each Claims Service Provider involved in the transfer and recorded in the Claims Technology Platform.

2. Claims File Transfer Process

2.1 Extract List

(a) icare will produce and provide Extract Lists to the Claims Service Provider, detailing the cohort of Claims to be transferred. The Extract List will advise the Transferring Claims Service Provider of the Claims Files to prepare for Claims File Transfer and the Receiving Claims Service Provider a list against which they can reconcile Claims Files received.

(b) The Transferring Claims Service Provider must confirm the accuracy of the Extract List.

(c) The volume of Claims in each cohort will be nominated by icare.

2.2 File Discrepancy

(a) The Transferring Claims Service Provider is responsible for resolving disputes with the Receiving Claims Service Provider regarding the quality of information contained in the transferred Claims Files, such as the quality of handover information or completeness of the Claims File.

(b) The Receiving Claims Service Provider must advise the Transferring Claims Service Provider of any discrepancies within 15 Business Days of receipt of the transferred Claims Files. The Receiving Claims Service Provider and the Transferring Claims Service Providers must seek a resolution to the discrepancies.

(c) Unresolved issues must be referred to the Transfer Lead who will mediate a resolution between the Receiving Claims Service Provider and the Transferring Claims Service Provider.

2.3 Claim Status

The Transferring Claims Service Provider must review all Open Claims before they are transferred and complete a File Status Report or equivalent as Approved by the Transfer Lead.

2.4 Key Document and Urgent Actions

The Transferring Claims Service Provider must undertake a process to flag key documents and urgent actions within the Claims File that are relevant to a Claims File Transfer, in a format that is Approved by icare.

2.5 Benefit Payments in Advance

(a) The Transferring Claims Service Provider must review the duration of the Certificates of Capacity for Claims with payment of weekly Benefits and the duration of payments under sections 36 – 40 of the 1987 Act. icare and the Receiving Claims Service Provider and the Transferring Claims Service Providers must agree the approach to be taken with regard to Benefit payments in advance.

(b) The Transferring Claims Service Provider must process all Employer Wage Reimbursement Schedules received up to five Business Days prior to the Claims File Transfer. Where further information is required to process the Wage Reimbursement Schedules, this information must be requested prior to the Transfer Date and a copy of the request must be attached to the Claims File.

2.6 Payment of Accounts and Invoices

(a) Subject to section 2.6(b), the Transferring Claims Service Provider must process all Approved accounts and invoices outstanding within the required timeframes at the time of the Claims File Transfer for all Claims being transferred.

(b) If the Transferring Claims Service Provider is unable to comply with section 2.6(a) it must, promptly after confirming the Claims File Transfer in accordance with section 1.6, provide icare with a list of Approved accounts or invoices it is unable to process with the required timeframe and seek icare's approval for an extension of time. Promptly after receipt of the list, icare must notify the Claims Service Provider whether it approves an extension of time in relation to one or more Approved accounts or invoices.

2.7 Disputes on Transferring Claims

(a) The Transferring Claims Service Provider must continue to manage any existing disputes on a Claims File, including those with the PIC or Independent Review Officer, until the Transfer Date.

(b) The Transferring Claims Service Provider must update the Claims File with details of such disputes, providing a summary of the dispute and status prior to the Transfer Date. This should include notifying PIC or IRO of the details of the Claims File Transfer.

(c) Where there are ongoing disputes through the PIC or IRO about a Claim due for transfer, the Transferring Claims Service Provider must identify and provide a list of such Claims to the Transfer Lead at least three weeks prior to the Transfer Date. On the Transfer Date, the Transferring Claims Service Provider must provide an updated list detailing the status of such Claims to the Transfer Lead.

(d) Following the Claims File Transfer, the Transferring Claims Service Provider must notify the Receiving Claims Service Provider directly of any new dispute matters received within 24 hours of becoming aware of the new dispute. This notice must be given by the method agreed with the Receiving Claims Service Provider and the Transfer Lead.

(e) Where the transferring Claim has active legal activity, the Receiving Claims Service Provider must ensure the continuity of services provided by the Transferring Claims Service Provider's legal Third Party Service Provider until the finalisation of that aspect of the Claim. The legal Third Party Service Provider must be advised of the Claims File Transfer at least four weeks before the Transfer Date, or with as much lead time as possible if the scheduled Transfer Date is less than four weeks from the date on which the Receiving Claims Service Provider becomes aware that it will assume responsibility for managing the Claim, and that advice may be provided electronically.

2.8 Closed and Reopened Claims

(a) icare, the Receiving Claims Service Provider and the Transferring Claims Service Providers will agree the approach to be taken with regard to communicating to Employers or Workers regarding the transfer of a Closed Claim.

(b) Before a Claims File Transfer, if an Employer or Worker requests to re-open a Closed Claim, the Transferring Claims Service provider must notify icare, and unless advised otherwise by icare the Transferring Claims Service Provider must manage the reopened Claim and advise the Employer or Worker of the status of the transfer based on the transfer plan. The Transferring Claims Service Provider must notify icare on a date as requested by icare, of any change to the status of Closed Claims.

(c) After a Claims File Transfer, if a Transferring Claims Service Provider receives a query regarding re-opening of a Closed Claim, the Transferring Claims Service Provider must notify the Receiving Claims Service Provider via the Claims Technology Platform, and the Receiving Claims Service Provider will be responsible for considering and responding to the query.

2.9 File Stakeholder Communication

(a) icare will coordinate with the Transferring Claims Service Provider to advise all active File Stakeholders of the Claims File Transfer using icare's Approved templates. icare reserves the right to instruct the Transferring Claims Service Provider to issue any communications to File Stakeholders on its behalf.

(b) icare reserves the right to seek information and make changes to any communication channel with all File Stakeholders including telecommunications such as phones, facsimile, interactive voice recordings, Case Manager direct lines as well as website content, social media protocol and content, physical mail systems or email systems.

(c) The Transferring Claims Service Provider must advise all other File Stakeholders of the Claims File Transfer (once icare provides Approval to do so).

2.10 Mailing List

The Transferring Claims Service Provider must provide icare additional details as an addendum to the Extract List in a format as Approved by the Transfer Lead, if requested following icare review of the Extract List. This includes identifying where a tailored communication approach is required.

2.11 Un-Actioned Correspondence

(a) The Transferring Claims Service Provider must manage any mail correspondence received in connection with a Claims File until the Transfer Date (if applicable) and take all reasonable steps to action all mail correspondence until the Transfer Date.

(b) The Transferring Claims Service Provider must clearly indicate to the Receiving Claims Service Provider what correspondence remains un-actioned as at the Transfer Date.

(c) All un-actioned correspondence as at the Transfer Date must be actioned by the Receiving Claims Service Provider. The Receiving Claims Service Provider must take all reasonable steps to action the correspondence within any required timeframes.

2.12 File Receipt Review

(a) Within five Business Days of the Transfer Date or as otherwise agreed by icare and the Receiving Claims Service Provider, the Receiving Claims Service Provider must make contact with the Worker or their representative (e.g. support person, carer, doctor) and Employer advising details of the new Case Manager assigned and their contact details.

(b) Within 15 Business Days of the Transfer Date or as otherwise agreed by icare and the Receiving Claims Service Provider, the Receiving Claims Service Provider must conduct a review of the Claims File. Unless otherwise advised by icare, the review must include:

(i) reviewing the File Status Report;

(ii) reviewing payment arrangements and schedules and the Wage Reimbursement Schedule;

(iii) identifying and reviewing urgent documents or matters to be actioned, including those flagged by the Transferring Claims Service Provider;

(iv) identifying and reviewing un-actioned correspondence and other items, and implementing action plans as required;

(v) noting any urgent action requirements and updating Claims Technology Platform and diarising as required; and

(vi) such other requirements as notified by icare to the Claims Service Provider from time to time.

(c) The Receiving Claims Service Provider must advise the Transferring Claims Service Provider and the Transfer Lead of any Claims File discrepancies within 15 Business Days after the Transfer Date.

2.13 Recoveries

As each cohort is transferred, the Transferring Claims Service Provider must provide a list to the Receiving Claims Service Provider of all recoveries included in the cohort transferred, including recoveries of Benefits from Workers after Work Injury Damages have been awarded and recoveries from third parties. The Receiving Claims Service Provider is to review the details of the recoveries and recognise any recoveries receivable. This includes both Open Claims and Closed Claims.

2.14 Data Quality

(a) The Transferring Claims Service Provider is responsible for ensuring that all Data associated with any Claim being transferred to a Receiving Claims Service Provider is accurate and up to date as of the Transfer Date, based on information available to the Transferring Claims Service Provider as of the Transfer Date. The Transferring Claims Service Provider must confirm to the Transfer Lead that all Data associated with any Claim being transferred to a

Receiving Claims Service Provider is accurate and up to date as at the Transfer Date, except to the extent specifically identified by the Transferring Claims Service Provider.

(b) If the Data that the Transferring Claims Service Provider provides to the Receiving Claims Service Provider is not accurate and up to date as of the Transfer Date, the Transferring Claims Service Provider must remediate that Data at its own cost. If it fails to do so within a reasonable time after being requested to do so by icare (as determined by icare, acting reasonably), the Transferring Claims Service Provider must reimburse icare's Direct Costs of remediating the Data, which may be incurred by icare remediating the Data itself or engaging the Receiving Claims Service Provider or another third party to remediate the Data.

2.15 Audits

icare may undertake audits before and after any Claims File Transfer. The Transferring Claims Service Provider and Receiving Claims Service Provider must provide the necessary support required for icare to complete any audits undertaken.

Schedule 8 Information Security and Management

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Schedule 8

Information Security and Management

Table of contents

Overview

This Schedule provides operational details in relation to the obligations of the Claims Service Provider in relation to management of records, privacy and Data quality in performing the Services under the Contract.

Glossary

Except where stated otherwise, capitalised terms used in this Schedule have the meaning set out in the Dictionary.

1. Records Management

1.1 Objectives

The objectives of this Schedule are that:

(a) Records of activities and transactions performed by the Claims Service Provider on behalf of icare are maintained regardless of whether the Record is in physical or digital format. This includes, but is not limited to, Records relating to:

(i) the Notification, administration, investigation, litigation, payment and other management of Claims, including invoices, tax and other financial documents relating to a Claim;

(ii) financial documents relating to the Claims Service Provider's management of icare's financial and taxation matters; and

(iii) documents relating to the management of Claims for damages arising out of the exposure to dust; and

(b) the Claims Service Provider efficiently and systematically manages the creation, receipt, maintenance and disposal of Records.

1.2 Records Management Programs

(a) Without limiting clause 9.1(c)(i) of the Contract, if the Claims Service Provider uses a system other than the Claims Technology Platform to collect or store Records, the Claims Service Provider must develop and implement a Records Management Program, tailored to the context of this Contract (namely, that Records are the property of icare and that documents and information relating to Claims are to be stored in icare's Claims Technology Platform), that includes systems, processes and controls that the Claims Service Provider maintains to ensure:

(i) creation, capture and protection of Records in all formats (including verbal communications), as required by Law and the Contract;

(ii) verification that physical Records which are imaged and converted to digital format are an accurate and complete reproduction of the original;

(iii) storage and preservation of physical Records is adequate when not converted to a digital format;

(iv) digital Records (including tax file number information) are secured and protected from loss and unauthorised access, use, modification or disclosure;

(v) Records are destroyed in accordance with this Schedule;

(vi) Records are transferred to the control and custody of icare (as requested by icare); and

(vii) compliance with relevant Laws and this Contract, including the standards described in this Schedule.

(b) The Claims Service Provider's Records Management Program must be authorised by the Claims Service Provider Authorised Representative.

(c) In respect of physical Records, the Claims Service Provider must include the following requirements in its Records Management Program:

(i) (**controls to find and locate Records**) Records are controlled in a system where they are able to be easily identified, located and retrieved;

(ii) (**protection**) Records are protected from known and reasonably identifiable hazards;

(iii) (**environment**) Records are stored in environmental conditions appropriate for their format and retention period;

(iv) (**shelving/packaging**) Records are stored using shelving and containers that ensure they are secure, accessible and protected from deterioration; and

(v) (**use of portable storage**) Records are not stored on physical media (e.g. CDs or USBs), to protect the information from storage technology obsolescence and data loss.

1.3 Procedures and practices developed to meet SIRA standards

The Claims Service Provider must collect and create Records in accordance with standards of practice for insurer claims administration and conduct issued by SIRA.

1.4 Physical Records and Digitisation

(a) The Claims Service Provider must not:

(i) create physical Records;

(ii) send electronic communications relating to Claims outside of the Claims Technology Platform except with icare's prior consent, which may be varied from time to time; or

(iii) have possession of any physical Records on the date it signs a Claims Service Provider Declaration.

(b) Notwithstanding section 1.4(a), where the Claims Service Provider:

(i) creates or receives physical Records in the provision of the Services, it must comply with its procedure for digitisation ("**Digitisation Procedure**") which must be Approved by icare before it is implemented and be consistent with Attachment 8.01 (Digitising Physical Records), unless otherwise approved by icare;

(ii) sends electronic communications relating to Claims outside of the Claims Technology Platform, it must upload those communications to the Claims Technology Platform; or

(iii) receives electronic communications relating to Claims outside of the Claims Technology Platform, it must upload those communications to the Claims Technology Platform.

(c) The Digitisation Procedure must:

(i) comply with the following standards published by Standards Australia:

(A) AS/NZS ISO 13008:2014 – Information and documentation - Digital records conversion and migration process; and

(B) AS/NZS ISO 13028:2012 – Information and documentation - Implementation guidelines for digitization of records;

(ii) include controls to ensure:

(A) digitised Records are captured, protected, processed, and stored in the Claims Technology Platform;

(B) technical specifications and formats recommended in standards for information and records are adopted for digitised file formats;

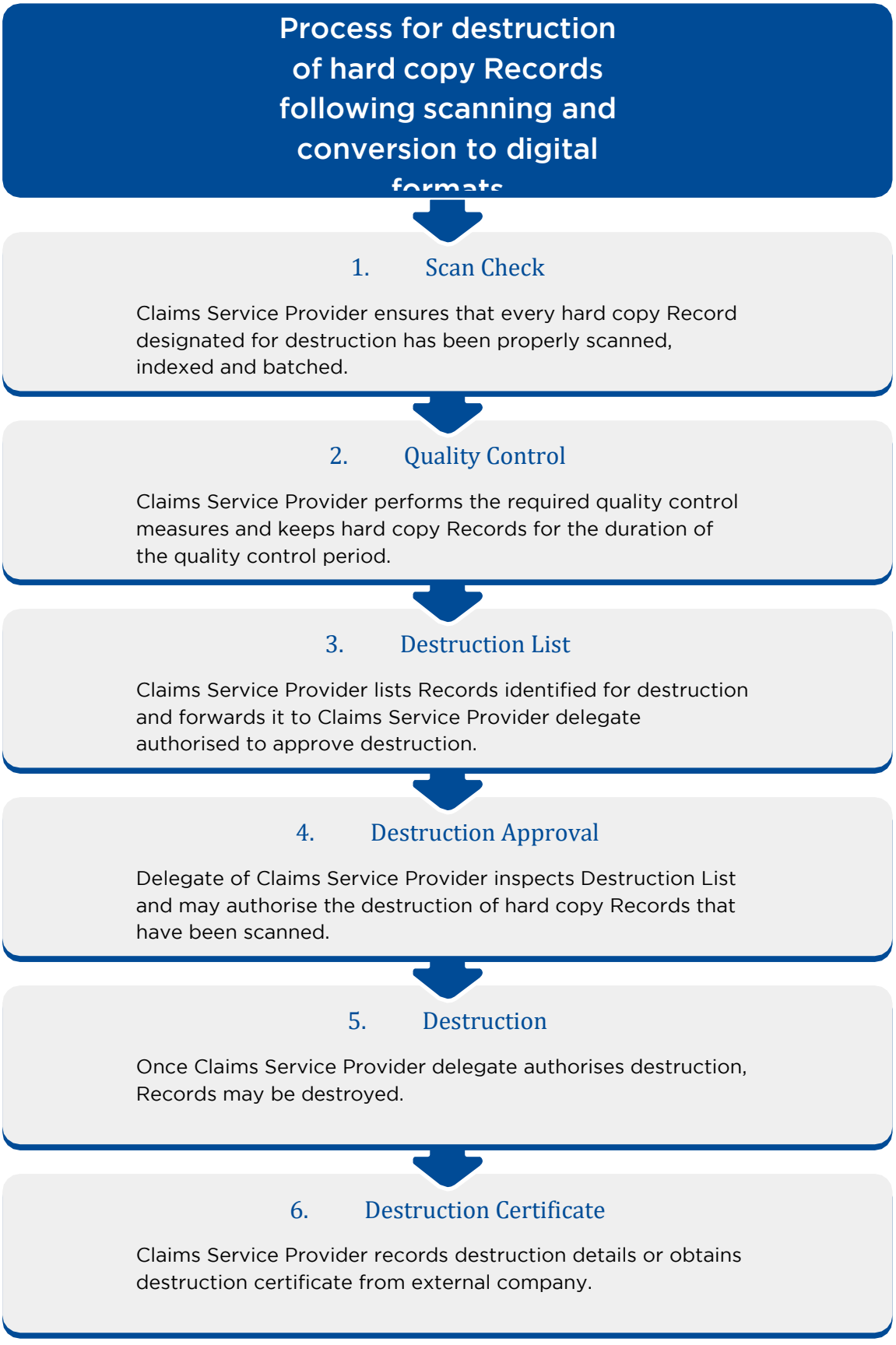
(C) digitised Records are not stored on portable storage media to protect the information from storage technology obsolescence and data loss;

(D) the Claims Service Provider has benchmarks and evidence that quality assurance processes are in place to verify, and if necessary rectify, the quality of the digital Record and image; and

(E) evidence in the form of destruction certificates that the physical Records were destroyed.

(d) The Claims Service Provider must destroy digitised physical Records in accordance with Attachment 8.01 (Digitising Physical Records) and the process set out in Diagram 1, provided that the Claims Service Provider complies with Law at all times.

Diagram 1



1.5 Storage of Digital Records

Without limiting clause 9.1(c)(i) of the Contract, if the Claims Service Provider uses a system other than the Claims Technology Platform to store icare's Records, the Claims Service must ensure that the system is able to:

(a) create and export data and information regarding the Records, including:

(i) a description of the Record and related content;

(ii) the structure of data, information and Records;

(iii) the business context in which the Records were created or received and used;

(iv) relationships with other data, information, Records and metadata;

(v) business actions and events; and

(vi) information that may be needed to retrieve and present data, information and Records;

(b) monitor digital formats at risk of obsolescence;

(c) retain the Records in accordance with all applicable Laws until such time as control and custody of the Records is returned to icare; and

(d) remove and destroy Records from the system when control and custody of Records is returned to icare.

1.6 Retention of physical Records and access to Records by icare

(a) Notwithstanding section 1.4(a), where the Claims Service Provider creates or receives physical Records in the provision of the Services, the Claims Service Provider must retain the Records until possession passes to icare in accordance with section 1.6(b) or they are destroyed in accordance with section 1.4(d).

(b) Upon written request by icare, the Claims Service Provider must provide icare with any physical Records in the Claims Service Provider's possession to allow icare to digitise the Records and store them in the Claims Technology Platform.

(c) If it is not technically feasible for the Claims Service Provider to digitise a Record or if it considers that it is not reasonable for it to do so (e.g. due to the size of the Record), the Claims Service Provider must:

(i) notify icare; and

(ii) comply with any instructions of icare in relation to the custody and digitisation of that Record.

1.7 Reporting requirements

Without limiting clause 9.1(c)(i) of the Contract , if the Claims Service Provider uses a system other than the Claims Technology Platform to collect or store Records, the Claims Service Provider must provide the reports detailed below to icare within the timeframes detailed in Attachment 3.05 (Reports Matrix):

(a) Destruction List Records – a list of all records that have been destroyed in the previous 12 months. This list must be provided to icare at wcrecords@icare.nsw.gov.au and the Claims

Service Provider mailbox (or another recipient advised by icare to the Claims Service Provider from time to time).

(b) **Custody Transfer List – Records** – the Claims Service Provider must ensure that details of all physical Claims Records to be transferred in accordance with icare's instructions are provided to wcrecords@icare.nsw.gov.au and the Claims Service Provider mailbox (or another recipient advised by icare to the Claims Service Provider from time to time).

(c) **Details of Claims File Holdings** – the Claims Service Provider must provide the number of Claim files in their custody. This must include a list of digital Records that are solely in the custody of the Claims Service Provider (i.e. those not transferred to icare). This must also include the number of physical Records stored by the Claims Service Provider. This must be provided to wcrecords@icare.nsw.gov.au and the Claims Service Provider mailbox (or another recipient advised by icare to the Claims Service Provider from time to time).

2. Privacy Management

2.1 Notification

(a) If the Claims Service Provider reasonably suspects that there may have been a Personal Information Security Incident, it must notify icare within two Business Days. This must include notice in writing (the form of which icare may prescribe from time to time) of the Personal Information Security Incident, including details of whether:

(i) it has been identified as a known Personal Information Security Incident (including whether it occurred in the past or is a present/ongoing Personal Information Security Incident) or a Near Miss; and

(ii) whether the Claims Service Provider considers that it is a Significant Personal Information Security Incident.

(b) If the Personal Information Security Incident is Significant the Claims Service Provider must await instruction from icare on how to respond except to the extent immediate action is necessary to contain the Personal Information Security Incident or in order to comply with its legal obligations.

(c) The Claims Service Provider must, subject to section 2.1(b):

(i) immediately make all reasonable efforts to contain any Personal Information Security Incident in respect of Data within the possession of the Claims Service Provider or any of its subcontractors or Key Input Providers; and

(ii) comply with reasonable procedures relating to the notification, management and resolution of Personal Information Security Incidents as notified by icare from time to time.

(d) The Claims Service Provider must promptly provide all relevant information to icare to enable icare to undertake an assessment of the Personal Information Security Incident in accordance with any voluntary or mandatory data breach notification scheme including but not limited to:

(i) the types of Personal Information involved in the breach;

(ii) the sensitivity of the Personal Information involved in the breach;

(iii) whether the Personal Information is protected by security measures;

(iv) the persons who have obtained, or who could obtain, the Personal Information;

(v) the likelihood that persons who have obtained, or could obtain, the Personal Information:

(A) have the intention of causing harm; or

(B) could circumvent the security measures;

(vi) the nature of the harm that has or may occur; or

(vii) any other matters specified in guidelines issued by the Information and Privacy Commission NSW about whether the disclosure is likely to result in serious harm to an individual to whom the information relates.

2.2 Privacy Management Plan

(a) The Claims Service Provider must submit an annual Privacy Management Plan to icare that:

(i) complies with:

(A) section 33 of the Privacy and Personal Information Protection Act 1998 (NSW); and

(B) the Information and Privacy Commission's guide to making Privacy Management Plans (as updated or replaced from time to time); and

(ii) includes details on the Claims Service Provider's:

(A) systems controls and processes relevant to the Claims Service Provider's compliance with its privacy obligations;

(B) risk analysis of any real or anticipated privacy issues that may impact the Claims Service Provider; and

(C) privacy training and refresher privacy training.

(b) The Claims Service Provider must comply with its Privacy Management Plan.

2.3 Privacy Complaints

Where a Personal Information Security Incident or privacy Complaint has been reported to the Information and Privacy Commission, or any other authority, by a third party, the Claims Service Provider must notify icare immediately and provide icare with a draft copy of the Claims Service Provider's response to the Complaint. The Claims Service Provider is not to respond directly to any authority, without icare's prior written consent, except to the extent that it is required to by Law.

2.4 Privacy Complaints Handling

The Claims Service Provider is required to manage Complaints in accordance with icare's Complaints Policy and its Privacy Management Plan. Subject to section 2.3, privacy Complaints should be dealt with by the Claims Service Provider in the first instance via their Complaint handling process and referred to icare's Privacy Team (privacy@icare.nsw.gov.au) if the complainant is unsatisfied with the outcome.

Any request for an internal review under section 53 of the *Privacy and Personal Information Protection Act 1998* (NSW) must be provided to icare's Privacy Team who will conduct the internal review, and the Claims Service Provider must co-operate with the internal review

procedure. This includes internal and external review matters at NSW Civil and Administrative Tribunal (**NCAT**). The Claims Service Provider must co-operate and assist in a timely manner and furnish documents as requested to icare.

3. Data Quality

3.1 Data quality management

(a) The Claims Service Provider must:

(i) capture, utilise, submit and enter accurate, complete and timely Data into the Claims Technology Platform;

(ii) ensure appropriate Data collection processes are in place that allow for the timely, accurate, and complete collection and submission entry of Data into the Claims Technology Platform;

(iii) monitor Data quality to ensure Data is being captured consistently, accurately and completely;

(iv) subject to section 1.14 of Schedule 1 in relation to Data relating to Claims, ensure that any incorrect Data is amended and resubmitted to icare in the Claims Technology Platform, including;

(A) the timely remediation of suspect and fatal errors identified through data submission processes to SIRA and within the timeframes specified by SIRA; and

(B) the remediation of Data as required by icare from time to time;

(v) implement controls to ensure the accurate translation of information to Data, to support the delivery of Services; and

(vi) ensure Data submitted to icare through the Claims Technology Platform meets the requirements detailed by icare, including all relevant fields, and complies with the relevant Manuals and applicable Laws.

4. Attachments

Attachment 8.01 (Digitising Physical Records)

Attachment 8.01 Digitising Physical Records

Scanning process

Various types of documentation are required to be made and kept to record the digitisation process and the ongoing management of the Record copies. Keeping such documentation will support the Records' admissibility in legal proceedings and assist in their management through time. Documentation includes:

- policies and procedures on the digitisation of Records and associated quality assurance and control processes; and
- documentation of the design of the digitisation systems indicating controls put in place to ensure the copies are complete, accurate and accessible.

Scanning specifications checklist:

☐ Records scanned in PDF-A format.

☐ Black and white scanning is used if the documents are text. Colour scanning is used if colour images are present in the document.

☐ Ensure scanner settings are set to at least 300 pixels per inch (ppi).

☐ Double sided and/or single sided scanning is used as required to capture all pages.

☐ Quality assurance (**QA**) checks: 10% of the scanned copy is checked to ensure that content is accurate, complete and legible (i.e. the scanned copy is the exact image of the physical Record). The requirement to conduct QA only applies to the extent the Claims Service Provider's records management practice involves the back-scanning of Records, not where Records are digitised by the Claims Service Provider upon receipt as part of its business as usual scanning processes.

*Aim for 100% accuracy with the QA of the scanned copies. Any specific errors or faults found in the scanned copy during the QA should be rectified through re-scanning.

Conditions for Destruction

The destruction of original or source Records that have been digitised is permitted subject to the following conditions:

- the physical Record was created **after** 1 January 1980.
- an authentic, complete and useable image of the Record is made (see guidance contained in table below).
- the physical Record is kept for quality control purposes for an appropriate length of time after copying (minimum of one month).

Authentic, complete and useable records

After a physical Record is digitised in accordance with this Attachment, the physical Record must be destroyed. The digitised information becomes the official Record of icare. Therefore, it is a requirement that digitised Records are authentic reproductions of the physical Record, in addition to being complete and useable.

Authentic	To be authentic, the copy must be the product of established, authorised and monitored processes. Measures which are required include: • policies and procedures on digitisation of Records are known by staff and authorised at a senior level; • processes to verify that images are accurate reproductions of the originals and use of image enhancement techniques to improve legibility and quality; • standard/sustainable formats and appropriate technical specifications; • process documentation, including technical specifications and descriptions of any image enhancement techniques are maintained; • 'read-only' controls in network servers used for storage of copies; and • security controls such as access passwords and audit trails are in place to prevent alteration of the copies.

Complete	To be complete, the digitised Record must be an accurate, legible reproduction of the physical Record in its entirety. This means that: • it must be legible at the required level of detail; • all pages, annotations, attachments and enclosures are captured; and • colour and tone should be captured where it provides meaning e.g. colour markings on maps and plans may be essential, but a coloured logo, letterhead or invoice may be less important. If there are concerns regarding accurate, legible reproduction then the Records must be rescanned or the originals must be retained.
Useable	To be useable, the digitised Record must be available and capable of being located and read. Measures include storing the digitised image in the Claims Technology Platform so the Record is: • available to all staff with appropriate access rights, • associated with metadata to locate the information and preserve its integrity, • retained until destruction is approved.

Schedule 9 Claims Technology Platform

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Schedule 9

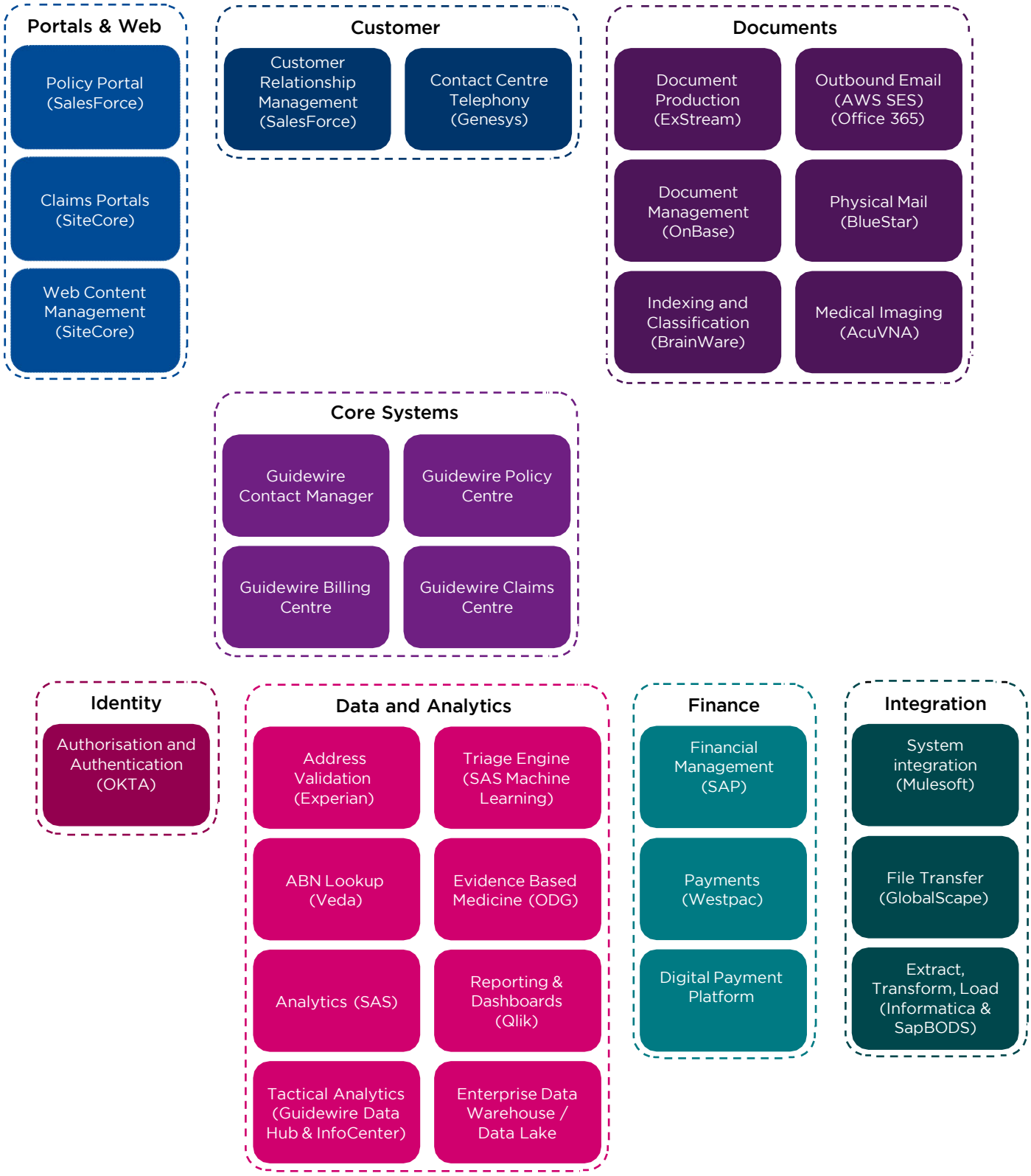
Claims Technology Platform

Table of contents

1. Claims Technology Platform

1.1 Claims Technology Platform Components

icare has its own Claims Technology Platform for the management of all Claims. The Claims Technology Platform is cloud-hosted and comprised of the following components (**Components**) as at the Commencement Date:



Core Activities	Description of service
Portal and Web	• Online customer self-service for employers and injured workers to lodge, manage and retrieve/upload documentation for their Claim with real-time transactions. • icare website which provides information to customers on the Scheme, performance and links to the portal and various forms.
Customer	• A customer relationship management platform that provides a single view of each customer (i.e. Workers and Employers) and includes a central Complaints management process. • The telephony platform provides for phone channels, IVR call routing, call matching to the Case Manager and grade of service metrics.
Guidewire	• Core Policy and Claims Management processes, including premium calculation, collection, wage Benefits calculation and treatment requests (including wage payments and reimbursement to Employers). • For service provider invoice payments, the platform provides for a fully digital next-day payment where providers are signed up for this service, or alternatively the platform offers an integrated optical character recognition and Data extraction process to support an automated payment process within certain parameters.
Documents	• Customer documents are automatically generated and pre-populated with the relevant Claim Data and distributed through multiple channels (i.e. email and post). • Inbound documents are categorised and linked to the relevant Claim for the Claims Management activity required. An exception process is designed and managed where these steps are not achieved. • All Claim documentation, medical files, emails are all stored and accessible against the relevant Claim.
Integrations	• To enable the workflow, automation and real-time transactions, each core platform sends and shares information including to external parties (e.g. Employers' Injury Management platforms).
Finance	• All payments to injured Workers, Employers and Third Party Services Providers are batched three times a day and sent to the bank (currently Westpac) for processing and payment. Financial reconciliations are managed and monitored.
Data and Analytics	• Upon initial Claim lodgement and ongoing management, the triage engine utilises evidence-based medicine to segment and allocate the Claim accordingly and utilises the evidence-based medicine to provide recommendations on treatment and Return to Work. • The Policy and Claim Data is copied and stored in icare's enterprise Data Warehouse. Reports (operational and regulatory) are created and used for the Scheme management.
Identity	• Identity management provides for user access and delegation controls (including financial delegation), and includes a pre-defined set of Claim management roles that can utilised. • This also provides for single sign-in to all of the Claims Technology Platforms.

1.2 General use

(a) Under clause 9.1 of the Contract Terms, the Claims Service Provider is required to use the Claims Technology Platform provided by icare (unless otherwise agreed with icare).

(b) The Claims Technology Platform is cloud-hosted with security protections and measures. The Claims Service Provider is required to have and maintain an appropriate (as determined by icare from time to time) standard operating environment for devices and establish a secure network connection to icare's virtual data centre at all times when it has access to the Claims Technology Platform.

(c) The Claims Service Provider must ensure its Equipment can support, and its Personnel can use, the Claims Technology Platform (including all Components) as updated from time to time in accordance with this Schedule.

(d) The Claims Service Provider must follow all reasonable instructions from icare with regards to the access, use, system maintenance, system updates (including updates to the Claims Service Provider's systems) and other activities associated with using the Claims Technology Platform, within the timeframes required by icare (or where no timeframe is provided, as soon as reasonably practicable). For clarity, the Claims Service Provider is not required to update icare's systems.

(e) icare is responsible for any costs associated with the hosting, licensing, support and maintenance of the Claims Technology Platform.

(f) The Claims Service Provider acknowledges that some license costs are based on the number of users and will ensure that its users are managed efficiently, ensuring that access is only requested for users who require it to perform the Services.

(g) For the avoidance of doubt, the Claims Service Provider is not required to develop IT builds to utilise the Components in section 1.1 when providing the Services. Where the Claims Service Provider intends to use bolt-on systems which interface with the Claims Technology Platform, it must seek icare approval and comply with the processes and requirements in accordance with section 2.

1.3 Security Patching

The Claims Service Provider is required to install and implement security patches on its own systems which integrate with the Claims Technology Platform where reasonably required by icare, within the timeframes notified by icare. icare will use reasonable endeavours to provide reasonable prior written notice of any requirement to install or implement patches. The Claims Service Provider acknowledges that some security patches may need to be installed and implemented urgently to maintain the security, reliability or integrity of the Claims Technology Platform. For clarity, icare will install and implement security patches on its own systems which integrate with the Claims Technology Platform.

1.4 Onboarding and Access

(a) The parties will act in accordance with the Approved Transition-In Plan in relation to the initial onboarding process in connection with the use of the Claims Technology Platform.

(b) The Claims Service Provider is required to integrate with icare's access control systems to enable single sign-on for their Personnel.

(c) The Claims Service Provider must request new user access and access changes through the Claims Service Provider's service desk.

(d) The Claims Service Provider must submit a user offboarding request no later than five Business Days after any user leaves the Claims Service Provider's organisation.

(e) The Claims Service Provider is required to undertake user access reviews every six months after icare's Acceptance of Transition-In to assess the validity of user access and delegations as required by icare.

2. Bolt-on systems

2.1 Approval required

Under clause 9.1(e) of the Contract Terms, the Claims Service Provider must not use any Claims Service Provider system that integrates with the Claims Technology Platform (**bolt-on system**) for the provision of the Services without prior icare Approval.

2.2 Requirements for bolt-on systems

To obtain approval for any proposed use of a bolt-on system, the Claims Service Provider must complete an impact assessment of the proposed bolt-on systems and implement any controls as required by icare and in accordance with the requirements set out below.

Level	Description	Requirements for approval
1	one-way interface from icare to the Claims Service Provider, real time Data unavailable. For example, the Claims Service Provider wishes to download Data.	• Security and privacy assessment; and • Information security controls commensurate with the type of Data to be downloaded.
2	one-way interface from icare to the Claims Service Provider, real time Data available. For example, the Claims Service Provider wishes to connect a system to icare's system in order to access information in real time.	In addition to Level 1 requirement listed above: • assessment of the security of the integration method; • assessment of any performance or operational impacts; and • assessment of any effort required from icare to establish the bolt-on system.
3	two-way interface between icare and the Claims Service Provider, real time Data available. For example, the Claims Service Provider wishes to extend the Claims Technology Platform with integration to perform both read and write transactions.	In addition to Levels 1 and 2 requirements above: • full assessment of the impact of the Claims Service Provider's extension on the Claims Technology Platform and its other users, including Data integrity assessment.

3. Maintenance and Incident Management

3.1 Maintenance Schedule

(a) Generally, icare will perform monthly maintenance on the Claims Technology Platform. The Claims Service Provider acknowledges that any urgent incidents may require an outage and that icare will notify the Claims Service Provider as soon as they become aware of the issue.

(b) The Claims Service Provider must provide written notice to icare at least ten Business Days in advance of any system operating environment maintenance in relation to the Claims Service Provider's environment that may affect the operations of the Claims Technology Platform.

3.2 System Monitoring

If there are service disruptions or latency issues with the Claims Technology Platform, icare may, following consultation and agreement with the Claims Service Provider, install Dynatrace (or other similar software monitoring tools) on the Claims Service Provider's staff computers to assist with the investigation and monitoring of such issues. Dynatrace installs a browser plug-in agent that enables monitoring of icare's application stack for system performance issues and outages.

3.3 Service Desk Support Model

The Claims Service Provider must support and implement the integrated service desk support model (**Service Desk Support Model**) to allow appropriate triaging, management, communication and escalation across system incidents, user access issues or requests. The Service Desk Support Model involves the integration of the Claims Service Provider's service desk platform with icare's platform via a bi-directional REST API to allow for the integration of incident and request records. The Service Desk Support Model allows both the Claims Service Provider and icare to create incident tickets and for tickets to be assigned to the appropriate party. As part of the Service Desk Support Model and icare's incident, change, request and problem management process, icare adopts the Information Technology Infrastructure Library (ITIL) version 4.

4. Claims Technology Platform Updates, Changes and Enhancements

4.1 Updates, changes and enhancements

(a) icare may implement updates, changes and enhancements to the Claims Technology Platform, or any requirements in respect of the use the Claims Technology Platform (including the required operating and security environment as set out in section 1.2 above) (**Platform Changes**), from time to time.

(b) icare is not required to make any Platform Changes, and will have sole discretion in respect of any Platform Change.

(c) For any Platform Change involving an update or upgrade to the Claims Technology Platform that may require the Claims Service Provider to update or modify its systems,

interfaces, Equipment, processes or procedures, or otherwise materially impact the Claims Service Provider, icare must, subject to section 4.1(d):

(i) provide reasonable prior notice of the Platform Change;

(ii) use reasonable endeavours to implement such Platform Change in the enterprise release schedule as set out in section 4.3.

(d) Where icare reasonably considers an urgent Platform Change must be implemented to:

(i) comply with any applicable Law or guidelines, including but not limited to WH&S and Workers Compensation Legislation; or

(ii) maintain or support the security, integrity or performance of the Claims Technology Platform,

then the obligations in section 4.1(c) will not apply and icare will implement the Platform Change, and provide notice to the Claims Service Provider (prior to the Platform Change, to the extent reasonably practicable).

(e) icare will use reasonable endeavours to consult with the Claims Service Provider in connection with planned Platform Changes through a co-design forum.

4.2 Co-Design Forum

(a) icare has established a co-design forum to ensure a collaborative approach between icare and Claims Service Providers, which facilitates high-quality and innovative co-design for enhancements to the Claims Technology Platform and considers process, technology and innovative ideas including, but not limited to:

(i) providing a sounding board and forum for icare to develop and test ideas and products relating to the design and implementation of enhancements to the Claims Technology Platform;

(ii) advising on wider co-design and stakeholder engagement processes to ensure effective participation;

(iii) assessing the size, complexity and impacts to overall Claims Technology Platform as part of decision making;

(iv) providing advice, guidance and direction in relation to the implementation of enhancements to the Claims Technology Platform, including identification of priorities; and

(v) assisting in disseminating information and communicating priorities.

(b) The Claims Service Provider must nominate two representatives with decision making authority to join the collaborative co-design forum.

(c) icare will consider input provided by the Claims Service Provider through the co-design forum in good faith but will retain sole discretion as to which changes and enhancements are made to the Claims Technology Platform.

(d) The Claims Service Provider acknowledges that icare is a NSW Government Agency and is subject to the NSW Procurement Policy Framework and processes for conducting any proof of concepts or acquiring new technology.

4.3 Enterprise Release Schedule

(a) icare will use reasonable endeavours to provide at least three months' prior notice to the Claims Service Provider of any planned enterprise releases.

(b) icare will provide notice to the Claims Service Provider as soon reasonably practicable as it becomes aware of any changes to the enterprise release calendar.

(c) The Claims Service Provider must nominate a representative to attend each monthly enterprise release forum.

(d) The Claims Service Provider must participate in user acceptance testing and provide validation that the Claims Technology Platform is operating as expected during each enterprise release and security patching implementation.

5. Requirements in relation to the Permitted IT System

This section 5 only applies to the extent that Claims are not managed by the Claims Service Provider on the Claims Technology Platform.

5.1 General

(a) The Permitted IT System must support the following processes:

(i) triage – manual Claims Service Provider process; and

(ii) establishment of information security systems.

(b) The Claims Service Provider must provide icare's Personnel with access to be able to review and oversee all of the Claims Service Provider's processes used to perform the Services in respect of Claims managed on the Permitted IT System. This must include access to all Equipment on which those Services are dependent, including remote access if required. The Claims Service Provider must also train icare's Personnel on the Permitted IT System, if so required by icare.

5.2 Incorporation of regulatory Data requirements and system validations as provided by SIRA or icare

Upon notification from icare, the Claims Service Provider will be required to update any Data sets and/or perform system validations that are stipulated by SIRA or icare in relation to the Permitted IT System and any Claims managed on the Permitted IT System. When making these changes, the Claims Service Provider must complete any update within the required timeframes stipulated by icare, and provide confirmation to icare once the modification has occurred.

5.3 Maintenance Schedule

The Claims Service Provider must ensure its maintenance schedule in respect of the Permitted IT System is aligned with that of icare in relation to the Claims Technology Platform. The Claims Service Provider will advise icare within 10 Calendar Days of any system downtime in relation to the Permitted IT System which will occur as a result of scheduled maintenance.

Schedule 10 Form of Performance Guarantee

icare™
Insurance and Care NSW

Schedule 10

Form of Performance Guarantee

Table of contents

Guarantee and Indemnity

#insert party name and ABN/ACN/ARBN# ("Guarantor")

Insurance and Care NSW **(ABN 16 759 382 489)** in its own right and acting for the Workers Compensation Nominal Insurer (ABN 83 564 379 108) ("Beneficiary")

Parties		
Guarantor	Name	#Insert full name#
	ABN/ACN/ARBN	#Insert#
	Address	#Insert#
	Email	#Insert#
	Attention	#Insert#
Trustee details for Guarantor acting as trustee	Trust Name	***[Note: complete the following section if the Guarantor is acting as trustee. If none, delete]*** **#Insert full name#**
	Trust's ABN	#Insert#
	Trust deed parties	#Insert details#
	Trust deed date	#Insert details#
Guarantor		***[Note: complete the following section if the Guarantor is partnership. If none, delete]*** Each person who, at any time on or after the date of this document, carries on business in partnership with other persons under the name #insert# or under a name substituted or further substituted for that name. The persons carrying on that business as at the date of this document are:
	Name	**#Insert full name#**
	ABN/ACN/ARBN	#Insert#
	Address	#Insert#
	Email	#Insert#
	Attention	#Insert#
Beneficiary	Name	**Insurance and Care NSW (ABN 16 759 382 489) in its own right and acting for Workers Compensation Nominal Insurer (ABN** 83 564 379 108)
	ABN	83 564 379 108
	Address	321 Kent Street Sydney NSW 2000
	Email	icareAuthorisedRep@icare.nsw.gov.au
	Attention	Mary Maini
Obligor	Name	**#Insert full name#**
	ABN/ACN/ARBN	#Insert#
	Address	#Insert Obligor's address#

		[Note: include the following section if the Obligor is a trustee. If none, delete]
Trustee details for Obligor acting as trustee		The person who, on or after the date of this document, is the trustee of the #insert name of trust# established under the trust deed dated #insert date# between #insert names of parties#. At the date of this document, that person is:
	Name	**#Insert full name**
	Address	#Insert address# A reference to the Obligor is a reference to it in its personal and any trustee capacity. ***[Note: include the following section if the Obligor is a partnership. If none, delete]*** The Obligor comprises each person who, at any time on or after the date of this document, carries on business in partnership with other persons under the name #insert# or under a name substituted or further substituted for that name. The person carrying on that business at the date of his document are:
	Name	***#Insert name#***
	Address	#Insert address#
Governing Law	New South Wales	
Date of guarantee and indemnity	See signing page	

1. Interpretation

1.1 Definitions

Unless the contrary intention appears, these meanings apply:

Agreement means the Contract for the provision of Nominal Insurer Workers Compensation Claims and Injury Management Services dated ***#insert date#*** 2022 between the Obligor and the Beneficiary.

Authorised Officer means a director or secretary of a party or any other person nominated by a party to act as an authorised officer for the purposes of this document.

Beneficiary means the person or persons so described in the Details.

Business Day means a day on which banks are open for general banking business in New South Wales (not being a Saturday, Sunday or public holiday in that place).

Corporations Act means the Corporations Act 2001 (Cth).

Costs includes charges and expenses, including those incurred in connection with advisers and any legal costs on a full indemnity basis.

Default Rate means the Interest Rate plus an additional 2%.

Details means the section of this document headed "Details".

Guarantor means the person or persons so described in the Details. If there are more than one, the Guarantor means each of them individually and every two or more of them jointly.

A person is **Insolvent** if:

(a) it is (or states that it is) an insolvent under administration or insolvent (each as defined in the Corporations Act); or

(b) it is in liquidation, in provisional liquidation, under administration or wound up or has had a controller (as defined in the Corporations Act) appointed to its property; or

(c) it is subject to any arrangement (including a deed of company arrangement or scheme of arrangement), assignment, moratorium, compromise or composition, protected from creditors under any statute, or dissolved (in each case, other than to carry out a reconstruction or amalgamation while solvent on terms approved by the Beneficiary); or

(d) an application or order has been made (and, in the case of an application which is disputed by the person, it is not stayed, withdrawn or dismissed within 14 days), resolution passed, proposal put forward or any other action taken, in each case in connection with that person, in respect of any of the above paragraphs; or

(e) it is taken (under section 459F(1) of the Corporations Act) to have failed to comply with a statutory demand; or

(f) it is the subject of an event described in section 459C(2)(b) or section 585 of the Corporations Act (or it makes a statement from which the Beneficiary reasonably deduces it is so subject); or

(g) it is otherwise unable to pay its debts when they fall due; or

something having a substantially similar effect to any of the things described in the above paragraphs happens in connection with that person under the law of any jurisdiction.

Interest Rate means the "Reference Lending Rate" (expressed as a percentage per annum) charged by Westpac Banking Corporation from time to time, as published in the Australian Financial Review, failing which it will be a similar rate selected by the Beneficiary which is charged by a major Australian trading bank.

Obligor means the person or persons so described in the Details.

Taxes means taxes, levies, imposts, charges and duties (including stamp and transaction duties) paid, payable or assessed as being payable by any authority together with any related fines, penalties and interest in connection with them, except if imposed on, or calculated having regard to, the net income of the Beneficiary.

1.2 References to certain general terms

Headings are for convenience only and do not affect interpretation. Unless the contrary intention appears, in this document:

(a) labels used for definitions are for convenience only and do not affect interpretation;

(b) the singular includes the plural and vice versa;

(c) a reference to a document includes any agreement or other legally enforceable arrangement created by it (whether the document is in the form of an agreement, deed or otherwise);

(d) a reference to a document also includes any variation, replacement or novation of it;

(e) the meaning of general words is not limited by specific examples introduced by "including", "for example" or "such as" or similar expressions;

(f) a reference to "**person**" includes an individual, a body corporate, a partnership, a joint venture, an unincorporated association and an authority or any other entity or organisation;

(g) a reference to a particular person includes the person's executors, administrators, successors, substitutes (including persons taking by novation) and assigns;

(h) a reference to a time of day is a reference to Sydney, Australia time;

(i) a reference to, dollars, $ or A$ is a reference to the currency of Australia;

(j) a reference to "**law**" includes common law, principles of equity and legislation (including regulations);

(k) a reference to any legislation includes regulations under it and any consolidations, amendments, re-enactments or replacements of any of them;

(l) a reference to "regulations" includes instruments of a legislative character under legislation (such as regulations, rules, by-laws, ordinances and proclamations);

(m) an agreement, representation or warranty in favour of two or more persons is for the benefit of them jointly and each of them individually;

(n) an agreement, representation or warranty by a Beneficiary binds the Beneficiary individually only;

(o) a reference to a group of persons is a reference to any two or more of them jointly and to each of them individually;

(p) a reference to any thing (including an amount) is a reference to the whole and each part of it;

(q) a reference to accounting standards is a reference to accounting standards, principles and practices generally accepted in the relevant place, consistently applied;

(r) a reference to an accounting term in an accounting context is a reference to that term as it is used in relevant accounting standards;

(s) a reference to "property" or "asset" includes any present or future, real or personal, tangible or intangible property, asset or undertaking and any right, interest or benefit under or arising from it.

1.3 Guarantors' rights and obligations individual

If more than one person is named as "Guarantor", each of them is liable for all the obligations under this document both individually and jointly with any one or more other persons named as "Guarantor".

2. Guarantee and indemnity

2.1 Consideration

The Guarantor acknowledges that the Beneficiary is acting in reliance on the Guarantor incurring obligations and giving rights under this document.

2.2 Guarantee

(a) The Guarantor unconditionally and irrevocably guarantees to the Beneficiary in accordance with the terms of this document the Obligor's compliance with the Obligor's obligations in connection with the Agreement, including each obligation to pay money.

(b) The Guarantor agrees to comply with those obligations on demand from the Beneficiary as if it were the principal debtor if:

(i) the Obligor does not comply with those obligations on the due date and in accordance with the Agreement;

(ii) an obligation the Obligor would otherwise have to comply with is found to be void, voidable or unenforceable other than as a result of the Beneficiary's acts or omissions; or

(iii) an Ipso Facto Event occurs.

An "Ipso Facto Event" means the Obligor is the subject of an announcement, application, compromise, arrangement, the appointment of a managing controller, or administration as described in section 415D(1), 434J(1) or 451E(1) of the Corporations Act or any process which under any law with a similar purpose may give rise to a stay on, or prevention of, the exercise of contractual rights.

(c) A demand may be made whether or not the Beneficiary has made demand on the Obligor.

(d) Should circumstances arise in which this guarantee and indemnity is validly invoked, the Guarantor must cause the due and punctual performance of the relevant obligations by, at its sole discretion:

(i) itself;

(ii) the Obligor; or

(iii) one or more of any of its directly or indirectly wholly owned subsidiaries,

provided that such performance must comply with all requirements of the Obligor under the Agreement, including as to subcontracting and location of performance.

(e) Notwithstanding any other provision of this guarantee and indemnity, the Guarantor shall be under no greater obligation or greater liability under this guarantee and indemnity than the Guarantor would have been under the Agreement if the Guarantor had been named as the Obligor therein.

2.3 Indemnity

The Guarantor indemnifies the Beneficiary against, and agrees to reimburse and compensate the Beneficiary for, any liability or loss arising from, and any Costs it incurs, if:

(a) an obligation the Obligor would otherwise have under the Agreement (including an obligation to pay money) is found to be void, voidable or unenforceable other than as a result of the Beneficiary's acts or omissions; or

(b) a representation or warranty by the Obligor in the Agreement is found to have been incorrect or misleading when made or taken to be made.

The Guarantor agrees to pay amounts due under this clause within five Business Days of demand from the Beneficiary. The Beneficiary need not incur expense or make payment before enforcing this right of indemnity.

2.4 Extent of guarantee and indemnity

Each of the guarantee in clause 2.2 ("Guarantee") and the indemnity in clause 2.3 ("Indemnity") is a continuing obligation despite any intervening payment, settlement or other thing and extends to all of the Obligor's obligations in connection with the Agreement. The Guarantor waives any right it has of first requiring the Beneficiary to commence proceedings or enforce any other right against the Obligor or any other person before claiming from the Guarantor under this document

2.5 Variations and replacements

The Guarantor acknowledges that the Agreement may be varied or replaced from time to time.

The Guarantor confirms that the obligations guaranteed under clause 2.2 ("Guarantee") include any obligations under the Agreement as varied or replaced. The Guarantor confirms that this applies regardless of:

(a) how the Agreement is varied or replaced; and

(b) the reasons for the variation or replacement; and

(c) whether the obligations decrease or increase or the Agreement is otherwise more onerous as a result of the variation or replacement.

This clause does not limit clause 6 ("Rights of the Beneficiary are protected").

2.6 Acknowledgment

The Guarantor acknowledges that, before entering into this document, it:

(a) was given a copy of the Agreement (and all documents giving rise to an obligation of the Obligor in connection with the Agreement) and had full opportunity to consider their provisions; and

(b) is responsible for making itself aware of the financial position of the Obligor and any other person who guarantees any of the Obligor's obligations in connection with the Agreement.

2.7 Release

The Beneficiary must release the Guarantor from this document if:

(a) the Beneficiary is satisfied that the Obligor has fully performed and discharged all of its obligations under the Agreement; and

(b) on or after 24 months after the expiration or termination of the Agreement has passed, the Beneficiary has given written notice to the Guarantor that in its reasonable opinion:

(i) there is no prospect that money or damages will become owing (whether actually or contingently) by the Obligor to the Beneficiary; and

(ii) no payment by the Obligor or the Guarantor is likely to be void, voidable or refundable under any law, including any law relating to insolvency.

Any release by the Beneficiary under this clause 2.7 must be in writing.

3. Interest

3.1 Obligation to pay

The Guarantor agrees to pay interest on any amount under this document which:

(a) is not paid on the due date for payment; and

(b) is not otherwise incurring interest.

The interest accrues daily from (and including) the due date to (but excluding) the date of actual payment (both before and after judgment as an independent obligation) and is calculated on actual days elapsed and using a year of 360 or 365 days (as determined by reference to usual market practice for the relevant currency).

The Guarantor agrees to pay interest under this clause on demand from the Beneficiary.

3.2 Rate of interest

The rate of interest applying to each daily balance is the Default Rate.

3.3 Compounding

Interest accrued but which has not been paid under clause 3.1 ("Obligation to pay") is added to the overdue amount at the end of each period of 30 days (or any other period the Beneficiary reasonably chooses). The first period begins on (and includes) the date for payment of the overdue amount. Interest is payable on the increased overdue amount at the rate set out in clause 3.2 ("Rate of interest") and in the manner set out in clause 3.1 ("Obligation to pay").

4. Payments

The Guarantor agrees to make payments (including by way of reimbursement) under this document:

(a) in full without set-off or counterclaim, and without any deduction or withholding in respect of Taxes unless prohibited by law; and

(b) if the payment relates to the obligations guaranteed, in the currency in which the payment is due, and otherwise in Australian dollars, in immediately available funds.

5. No merger

This guarantee and indemnity does not merge with or adversely affect, and is not adversely affected by, any of the following:

(a) any other guarantee, indemnity, mortgage, charge or other encumbrance, or other right, power or remedy to which the Beneficiary is entitled; or

(b) a judgment which the Beneficiary obtains against the Guarantor, the Obligor or any other person in connection with the Agreement.

The Beneficiary may still exercise its rights under this document as well as under the guarantee, indemnity, judgment, mortgage, charge or other encumbrance or the right, power or remedy.

6. Rights of the Beneficiary are protected

The Guarantor agrees that rights given to the Beneficiary under this document, and the Guarantor's liabilities under it, are not affected by any act or omission or any other thing which might otherwise affect them under law or otherwise. For example, those rights and liabilities are not affected by:

(a) any act or omission:

(i) varying, replacing, supplementing, extending or restating in any way and for any reason any agreement or arrangement under which the obligations guaranteed under clause 2.2 ("Guarantee") are expressed to be owing;

(ii) releasing the Obligor or giving the Obligor a concession (such as more time to pay);

(iii) releasing any person who gives a guarantee or indemnity in connection with any of the Obligor's obligations;

(iv) by which a person becomes a Guarantor after the date of this document;

(v) by which the obligations of any other person who guarantees any of the Obligor's obligations (including obligations under this document) may become unenforceable;

(vi) by which any person who was intended to guarantee, or provide a security interest securing, any of the Obligor's obligations does not do so, or does not do so effectively;

(vii) by which a person who is co-surety or co-indemnifier is discharged under an agreement or by operation of law;

(b) a person dealing in any way with the Agreement or this document;

(c) the death, mental or physical disability, or liquidation, administration or insolvency of any person including the Guarantor or the Obligor;

(d) changes in the membership, name or business of any person;

(e) acquiescence or delay by the Beneficiary or any other person.

7. Guarantor's rights are suspended

As long as any obligation is required, or may be required, to be complied with in connection with this document, the Guarantor may not, without the Beneficiary's consent:

(a) reduce its liability under this document by claiming that it or the Obligor or any other person has a right of set-off or counterclaim against the Beneficiary; or

(b) claim, or exercise any right to claim, to be entitled (whether by way of subrogation or otherwise) to the benefit of another guarantee, indemnity, mortgage, charge or other encumbrance:

(i) in connection with the Agreement or any other amount payable under this document; or

(ii) in favour of a person other than the Beneficiary in connection with any obligations of, or any other amounts payable, by the Obligor to, or for the account of, that other person in connection with this Agreement; or

(c) claim an amount from the Obligor, or another guarantor (including a person who has signed this document as a "Guarantor"), under a right of indemnity or contribution; or

(d) claim an amount in the liquidation, administration or insolvency of the Obligor or of another guarantor of any of the Obligor's obligations (including a person who has signed this document as a "Guarantor").

If the Beneficiary asks, the Guarantor agrees to notify any relevant person of the terms of this clause and other parts of this document that may be relevant. The Guarantor also authorises the Beneficiary to do so at any time in its discretion and without first asking the Guarantor to do it. This applies despite anything else in this document.

This clause continues until the Beneficiary releases the Guarantor in accordance with clause 2.7 of this document.

8. Reinstatement of rights

Under law relating to liquidation, administration, insolvency or the protection of creditors, a person may claim that a transaction (including a payment) in connection with this document or the Agreement is void or voidable. If a claim is made and upheld, conceded or compromised, then:

(a) the Beneficiary is immediately entitled as against the Guarantor to the rights in connection with this document or the Agreement to which it was entitled immediately before the transaction; and

(b) on request from the Beneficiary, the Guarantor agrees to do anything (including signing any document) to restore to the Beneficiary any mortgage, charge or other encumbrance (including this document) held by it from the Guarantor immediately before the transaction.

The Guarantor's obligations under this clause are continuing obligations, independent of the Guarantor's other obligations under this document and continue after this document, or any obligation arising under it, ends.

9. Representations and warranties

The Guarantor represents and warrants (except in relation to matters disclosed to the Beneficiary and accepted by the Beneficiary in writing) as at the date of this document that:

(a) (***status***) it has been incorporated or formed in accordance with the laws of its place of incorporation or formation, is validly existing under those laws and has power and authority to carry on its business as it is now being conducted; and

(b) (***power***) it has power to enter into this document, comply with its obligations under it and to exercise its rights under it; and

(c) (***no contravention***) the entry by it into, its compliance with its obligations and the exercise of its rights under, this document do not and will not conflict with:

(i) its constituent documents or cause a limitation on its powers or the powers of its directors to be exceeded; or

(ii) any law binding on or applicable to it or its assets; or

(iii) any document or agreement binding on or applicable to it or its assets or constitute a review event, event of default, termination, cash cover requirement, prepayment or similar event (each however described) under any such document or agreement where this has had or is likely to have a material adverse effect; and

(d) (***authorisations***) it has in full force and effect each authorisation necessary for it to enter into this document, to comply with its obligations and exercise its rights under it, and to allow them to be enforced; and

(e) (***validity of obligations***) its obligations under this document are valid and binding and are enforceable against it in accordance with its terms subject to any stamping and registration requirements, applicable equitable principles and laws generally affecting creditors' rights; and

(f) (***benefit***) it benefits by entering into this document; and

(g) (***solvency***) it and each of its subsidiaries is not Insolvent; and

(h) (***litigation***) there is no current, pending or (to its knowledge, having made due enquiry) threatened proceeding, investigation or claim affecting it or any of its subsidiaries or any of their assets before a court, authority, commission or arbitrator in which a decision against it or the subsidiary is likely and which (either alone or together with other decisions) would be likely to have a material adverse effect with respect to its ability to perform its obligations hereunder; and

(i) (***not a trustee***) unless stated in the Details, it does not enter into this document as trustee; and

(j) (***no immunity***) neither it nor any of its subsidiaries or their assets has immunity from the jurisdiction of a court or from legal process.

10. Costs

The Guarantor agrees, within five Business Days of demand, to pay or reimburse:

(a) (***transaction costs***) the Beneficiary's reasonable third party Costs in connection with giving and considering consents, waivers, variations, discharges and releases and providing documents and other information in connection with this document;

(b) (***other costs***) the Beneficiary's Costs of exercising, enforcing or preserving rights, powers or remedies (or considering doing so) in connection with this document; and

(c) (***taxes***) all stamp duty, registration fees and similar taxes or fees payable or assessed as being payable in connection with this document or any other transaction contemplated by this document (including any fees, fines, penalties and interest in connection with any of those amounts). However, the Guarantor need not pay or reimburse against any fees, fines, penalties or interest to the extent they have been imposed because of the Beneficiary's delay.

Money paid to the Beneficiary by the Guarantor must be applied first against payment of Costs under this clause then against other obligations under this document in any way the Beneficiary considers appropriate.

11. Dealing with interests

The Beneficiary may assign or otherwise deal with its rights under this document in any way it considers appropriate. If the Beneficiary does this, the Guarantor may not claim against any assignee (or any other person who has an interest in this document) any right of set-off or other rights the Guarantor has against the Beneficiary.

12. Notices and other communications

12.1 Form - all communications

Unless in this document expressly state otherwise, all notices, certificates, consents, approvals, waivers and other communications in connection with this document must be in writing, signed by the sender (if an individual) or an Authorised Officer of the sender.

All communications (other than email communications) must also be marked for the attention of the person referred to in the Details (or, if the recipient has notified otherwise, then marked for attention in the way last notified).

Email communications must state the first and last name of the sender and are taken to be signed by the named sender.

12.2 Delivery

Communications must be:

(a) left at the address referred to in the Details; or

(b) sent by prepaid ordinary post (airmail, if appropriate) to the referred to in the Details; or

(c) sent by email to the address referred to in the Details.

If the intended recipient has notified changed contact details, then communications must be sent to the changed contact details.

12.3 When effective

Communications take effect from the time they are received or taken to be received under clause 12.4 ("When taken to be received") (whichever happens first) unless a later time is specified in the communication.

12.4 When taken to be received

Communications are taken to be received:

(a) if sent by post, six Business Days after posting (or ten days after posting if sent from one country to another); or

(b) if sent by email:

(i) when the sender receives an automated message confirming delivery; or

(ii) four hours after the time sent (as recorded on the device from which the sender sent the email) unless the sender receives an automated message that the email has not been delivered,

whichever happens first.

Where an email is sent or received after 5:00pm on a Business Day or a day which is not a Business Day, it will be taken to be received at 9:00am on the next Business Day.

13. General

13.1 Set-off

The Beneficiary may set off any amount owing by the Beneficiary (whether or not due for payment) to the Guarantor against any amount due for payment by the Guarantor to the Beneficiary in connection with this document.

13.2 Indemnities

Any indemnity, reimbursement, payment or similar obligation in this document given by the Guarantor:

(a) is a continuing obligation despite the satisfaction of any payment or other obligation in connection with this document, any settlement or any other thing; and

(b) is independent of the Guarantor's other obligations under this document or any other document; and

(c) continues after this document, or any obligation arising under it, ends.

It is not necessary for the Beneficiary to incur expense or make payment before enforcing a right of indemnity in connection with this document.

13.3 Partial exercising of rights

If the Beneficiary does not exercise a right, power or remedy in connection with this document fully or at a given time, the Beneficiary may still exercise it later.

13.4 Remedies cumulative

The Beneficiary's rights, powers and remedies in connection with this document are in addition to other rights, powers and remedies given in any other document or by law independently of this document.

13.5 Guarantor bound

This guarantee and indemnity binds the Guarantor even if another person who was intended to sign does not sign it or is not bound by it.

13.6 Counterparts

This guarantee and indemnity may consist of a number of copies, each signed by one or more parties to the guarantee and indemnity. If so, the signed copies are treated as making up the one document.

13.7 Governing law

The law in force in the place specified in the Details governs this document. The parties submit to the non-exclusive jurisdiction of the courts of that place.

EXECUTED as a deed

Signing Page

GUARANTOR

[Note: appropriate execution clause to be inserted]

BENEFICIARY

SIGNED, SEALED AND DELIVERED by **INSURANCE AND CARE NSW (ABN 16 759 382 489) in its own right and acting for and on behalf of the WORKERS COMPENSATION NOMINAL INSURER (ABN 83 564 379 108) by its duly authorised representatives** in the presence of:

.....	.....
Signatures of witness	Signature of authorised representative
.....	.....
Name of witness (block letters)	Name of authorised representative
.....	.....
Signatures of witness	Signature of authorised representative
.....	.....
Name of witness (block letters)	Name of authorised representative

Date of execution by last party: _____ December 2022

icare.nsw.gov.au

Schedule 11 Special Conditions

Note: Schedule 11 is commercial-in-confidence and not included in this copy for disclosure under Part 3 Div 5 of the *Government Information (Public Access) Act 2009*.

Schedule 12 Draft Transition-In Plan

icare™
Insurance and Care NSW

Schedule 12

Transition-In Plan

Contents

1. Document information

1.1. Purpose

(a) This document is a draft Transition-In Plan for the purposes of clause 5.1(a) of the Contract.

(b) The purpose of this Transition-In Plan is to set out the activities the Claims Service Provider must perform pursuant to Section C of the Contract, to ensure that the Claims Service Provider is onboarded satisfactorily and ready to commence delivery of Services from the date specified in this Transition-In Plan.

1.2. Definitions and interpretation

Capitalised terms used in this Schedule 12 (Draft Transition-In Plan) have the meaning set out in the Dictionary (unless defined otherwise).

1.3. Document maintenance

(a) The Claims Service Provider is responsible for maintaining the Transition-In Plan. For any queries or problems with this document please contact the person(s) listed in section 1.4. The Claims Service Provider must notify icare of any changes to the key contacts by notice in accordance with clause 61.2 of the Contract.

(b) Changes to the Transition-In Plan are subject to Approval by icare.

1.4. Key contacts

Any general queries regarding this document should be directed to:

[Name]
[Title]
[Claims Service Provider]
[E-mail]
[Phone]

1.5. Communication during Transition

All communication regarding the Transition-In Plan or Transition-In in general must be conducted in accordance with clause 2.3 (Communication) of Schedule 3 (Performance Management & Governance) to the Contract.

1.6. Reporting and governance

During the Transition-In Period the Claims Service Provider must report to icare on the status of the Transition-In. Reporting requirements will be determined as part of the Transition-In or as otherwise notified by icare. The reporting requirements may include:

(a) attending regular Transition-In working group meetings;

(b) providing regular status reporting against agreed criteria;

(c) identifying and managing risks and issues related to the Transition-In; and

(d) adequately identifying, addressing and closing assigned actions.

Unless otherwise specified by icare, icare will manage the Transition-In using information provided by the Claims Service Provider. The parties must maintain the documents set out in the following table which are related to the Transition-In Plan:

Document	Description	Updates
Risk Management Plan	The overarching plan to deal with risks and issues during the Transition-In Period	Weekly
Risk Register	A listing of all Transition-In risks rated by severity and likelihood, risk owner and mitigation in accordance with the risk framework. The Risk Register will be jointly formulated between the Claims Service Provider and icare	Weekly
Recruitment and/or personnel tracker	A list of all the roles required by the Claims Service Provider and a record of progress in developing role descriptions, advertising, recruiting and onboarding each role	Weekly

1.7. Contingency planning

Contingencies for extreme, high and medium risks will be developed by the Claims Service Provider and icare and a workshop will be held to discuss and agree the impact of invoking such contingencies on icare processes and customers.

1.8. icare assistance and responsibilities

icare will provide the Claims Service Provider with information and assistance during the Transition-In Period. This assistance will include:

(a) establishment of and participation in the Transition-In Working Group;

(b) information and support to assist the Claims Service Provider in understanding icare's systems;

(c) considering requests for Approval of changes to the Transition-In Plan;

(d) providing lists of policies and/or Claims to be managed by the Claims Service Provider;

(e) providing critical go-live acceptance criteria and detailed readiness criteria for Acceptance of Transition-In; and

(f) providing assistance with communication strategies to workers, employers, and other key scheme stakeholders related to Transition-In activity.

1.9. Audits

icare may undertake audits before and/or after any Transition-In activity in accordance with clause 46.5 of the Contract. The Claims Service Provider must provide the necessary support and co-operation required for icare to complete any audits undertaken.

2. Section A – Transition-In

2.1. Transition-In objectives

(a) The Transition-In objectives are for the Claims Service Provider to be onboarded satisfactorily and ready to deliver the Services form the date specified in this Transition-In Plan.

(b) This document is divided into sections that deal with common elements of the Transition-In.

2.2. Transition-In timeline

(a) The table below outlines:

(i) the indicative Readiness Gates, outlined in chronological order;

(ii) the activities that the Claims Service Provider must perform in respect of each Readiness Gate before it may proceed to the next Readiness Gate; and

(iii) the indicative date by which the criteria for each Readiness Gate must be satisfied by the Claims Service Provider..

(b) icare will (in consultation with the Claims Service Provider) assess whether the Claims Service Provider has achieved the criteria for each Readiness Gate to determine if the Claims Service Provider is ready and able to move to the next Readiness Gate.

[Note: This section is to be included for new Claims Service Providers]

- Gate #0 – Transition team established, and key deliverables to achieve transition understood
- Gate #1 – Joint program timeline developed with key deliverables established at Gate #0 mapped, and critical path shown. Core structure for organisation within icare's Guidewire and Telephony instance has been shared
- Gate #2 – Structures established at Gate #1 built and tested in pre-production or production environments, Service Desk integration planned
- Gate #3 – Go-live systems and support structures established, capacity and capability requirements met to commence claims management, Service Desk integration tested

Readiness Gate	Details	Indicative Readiness Gate Date
#0	• Engagement with the Claims Service Provider commences. • Ways of working established and agreed – principles, RAID overview and expectations • Risk Register produced with risks identified and mitigating actions indicated. • icare and Claims Service Provider Transition-In team confirmed. • New Claims Service Provider onboarding reference pack provided and delivery roadmap shared.	TBA
#1	• Training delivery logistics and schedule finalised. • Training users provisioned. • Integrated delivery roadmap 2023 created. • icare trainers onboarded to commence training. • Training environment available and support framework established. • Market share outlook confirmed. • Telephony approach and implementation plan agreed. • Claims Service Provider user provisioning process commences. • Claims Service Provider structure and roles finalised in line with icare's requirements. • All delivery items discussed up to Readiness Gate #0 closure completed.	TBA
#2	• Performance monitoring against service standards outlined. • Training delivery to Claims Service Providers commenced with reporting to icare. • Business readiness indicators on track. • Training environment operational and support framework in force. • Service Desk integration complete. • Claims Service Provider structure and queues set up in production. • Claims Service Provider telephony set up and tested	TBA

Readiness Gate	Details	Indicative Readiness Gate Date
	• Systems and supporting processes connected and established for go-live (releases, incident management etc). • SFTP connection established, tested and operationalised for daily extract reports. • Claims Service Provider is ready to ensure data quality will be monitored/maintained during operations. • Claims Service Provider supports operational end-to-end testing.	
#3	• Business go-live: all systems and business requirements in place. • Readiness dashboard 'green' and go live checklist complete. • Operational end-to-end testing successfully complete. • Claims Service Provider ready to operate in line with finance requirements and has relevant access. • Claims Service Provider ready to action employer transfer requests and and/or policy/claim transfers as part of market share allocation. • Professional standards and capability baseline assessment completed. • All users provisioned. • Service Desk integration tested and signed off. • Hypercare (operational and tech) support process agreed and established. • Dress rehearsal plan finalised and agreed. • Claims Service Provider staff aware of icare capability assessment after go-live. • Operational reporting integrated and Claims Service Provider is ready to utilise in day-to-day operations (both Qlik and daily extract reports). • Ongoing BAU governance forums established.	TBA

Readiness Gate	Details	Indicative Readiness Gate Date
	• Handover to BAU completed to the satisfaction of both parties, including RAID closure and ways of working wrap up.	

[Note: This section is to be included for Incumbent Claims Service Providers]

- Gate #0 – Transition team established, and key deliverables to achieve transition understood
- Gate #1 – Joint program timeline developed with key deliverables established at Gate #0 mapped, and critical path shown. Core structure for required changes within icare's Guidewire and Telephony instance have been shared
- Gate #2 – Structures established at Gate #1 deployed in production environments, Service Desk integration completed (if applicable).
- Gate #3 – Go-live systems and support structures established, capacity and capability requirements met to complete transition into new claims model and/or increase market share

Readiness Gate	Details	Indicative Readiness Gate Date
#0	• Engagement with incumbent Claims Service Provider commences. • Ways of working established and agreed – principles, RAID overview and expectations. • Risk Register produced with risks identified and mitigating actions indicated. • icare and Claims Service Provider transition team confirmed. • Learning Management System in place (as applicable). • Claims model change delivery; scope, timing communicated.	TBA
#1	• Integrated delivery roadmap for 2023 created. • Market share outlook confirmed. • Risk register produced for claims model changes, with mitigating actions.	TBA

Readiness Gate	Details	Indicative Readiness Gate Date
	• Claims Management RACI (2023) implemented. • Daily data extract report - input to additional fields provided by the Claims Service Provider. • Claims Service Provider to establish and implement frameworks and Documentation required under the Contract. • Telephony approach and implementation plan agreed. • Claims Service Provider structure and roles finalised in line with icare's requirements. • All delivery items discussed up to Readiness Gate #0 closure completed.	
#2	• Agreed processes in place for market allocation activity. • Performance monitoring against service standards outlined. • Readiness for March 2023 enterprise release including operational testing completed and hypercare processes established. • Business readiness indicators on track for March 2023 (or 1st) enterprise release. • Claims Service Provider branding and mailboxes established including customer channels. • Claims Service Provider telephony set up, tested and operational. • Service Desk integration complete. • Professional standards and capability roadmap established. • Claims Service Provider supports operational end-to-end testing.	TBA
#3	• Business go-live: all systems and business requirements in place. • Claims Service Provider ready to action employer transfer requests and and/or policy/claim transfers as part of market share allocation.	TBA

Readiness Gate	Details	Indicative Readiness Gate Date
	• Business readiness indicators on track for May 2023 (or 2nd) enterprise release. • Business readiness dashboard 'green': all systems and business requirements in place. • All required Claims Service Provider users provisioned. • Service Desk integration (as required) tested and signed off. • Dress rehearsal plan finalised and agreed ready for deployment. • Hypercare (operational and tech) support process agreed and established. • Claims Service Provider monitoring in place to assess resourcing requirements in the first 12 months. • Ongoing BAU governance forums established. • Handover to BAU completed to the satisfaction of both parties, including RAID closure and ways of working wrap up.	

3. Project Controls

3.1. Transition-In working Group

(a) The parties must procure that a committee (**Transition-In Working Group**) is established before or promptly after the Commencement Date.

(b) The Transition-In Working group is to comprise the following representatives:

(i) the icare Transition-In Manager;

(ii) a senior employee of icare;

(iii) the Claims Service Provider Transition-In Manager; and

(iv) a senior employee of the Claims Service Provider.

(c) Every week during the Transition-In Period (or at such other frequency as the parties may agree), icare and the Claims Service Provider must procure that the Transition-In Working Group meets for the purposes of considering issues arising out of Transition-In, including:

(i) the actions taken, and to be taken, by the parties under or in connection with implementation of the Transition-In Plan;

(ii) any actual or potential delays in the implementation of the Transition-In Plan; and

(iii) any actual or potential disputes.

(d) Each party must use reasonable endeavours to give the other at least 2 Business Days' written notice of any matters which it wants to have discussed at the next Transition-In Working Group meeting.

3.2. Replacements

If a party wishes to replace its representative under section 3.1(b) or if a party's representative is unable to perform its duties for any prolonged period or if that representative is no longer employed by that party, then that party will:

(a) replace that representative with another suitably qualified and experienced representative as soon as reasonably practicable; and

(b) give notice of the details of the replacement representative to the other party as soon as reasonably practicable after the replacement takes effect.

3.3. Transition-In readiness

Operational readiness tests of the systems and the processes that the Claims Service Provider has in place will be undertaken in accordance with the timeframes outlined in the table set out in section 3.5.

3.4. Reporting timelines and format

The Claims Service Provider will provide a weekly aggregated Transition-In progress report. This report will:

(a) detail the current status of the Transition-In, including Deliverables provided and how the Claims Service Provider is tracking against relevant Milestones; and

(b) identify any actual or anticipated problems and proposed solutions to those problems.

3.5. Acceptance Criteria

(a) Acceptance Criteria are based on the project Deliverables and are linked to Contract requirements as agreed with icare. The Acceptance Criteria provide an objective assessment of project readiness and the completion of each Deliverable as defined in this Transition-In Plan.

(b) The table below outlines::

(i) the Deliverables that the Claims Service Provider must provide in connection with this Transition-In Plan;

(ii) the Acceptance Criteria that the Claims Service Provider must satisfy in order for each Deliverable to be Accepted by icare in accordance with the Acceptance process set out in clause 5.3 of the Contract;

(iii) any artifacts or other evidence the Claims Service Provider must provide in order to demonstrate that it has satisfied the Acceptance Criteria;

(iv) the date each Deliverable must be submitted by the Claims Service Provider for Acceptance; and

(v) the Milestone Dates for Acceptance, being the date each Deliverable must satisfy the applicable Acceptance Criteria and be Accepted by icare.

(c) If any Acceptance Criteria to be determined by the Transition-In Working Group after the Commencement Date, have not been determined within one month of the applicable Milestone Date for Acceptance, icare may, acting reasonably, notify the Claims Service Provider of the applicable Acceptance Criteria.

No.	Deliverables	Acceptance Criteria	Evidence protocol	Date submitted for Acceptance	Milestone Date for Acceptance
1.	Ways of working and governance	• icare and the Claims Service Provider have established a shared and agreed 'ways of working'.	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]
		• A robust governance process has been operationalised to support onboarding activity.			
2.	Contract, remuneration and performance	• Obligations operationalised by the Claims Service Provider and shared governance forums and routines established.	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]
		• Performance against service standards operationalised including RTW and other key metrics.			
		• Transition-In remuneration arrangements understood and agreed (if applicable).			
3.	Systems connectivity	• System overview has been provided and the Claims Service Provider has demonstrated that it has a thorough understanding of icare's systems and can operationalise any required changes.	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]
		• Connectivity between the Claims Service Provider and icare's systems has been established and tested including Service Desk integration,			

No.	Deliverables	Acceptance Criteria	Evidence protocol	Date submitted for Acceptance	Milestone Date for Acceptance
		incident management and enterprise release processes etc.			
4.	Claims Service Provider structure system build	• The Claims Service Provider has established an operational organisational structure (structure, roles, groups, teams, users and queues etc) through which the Services will be delivered, in line with the roles defined by icare.	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]
		• Ongoing user access review processes have been established and operationalised.			
5.	Telephony platform	• The telephony solution has been implemented, tested and is ready for use.	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]
		• All call recording requirements and telephony reporting requirements are established and operationalised.			
6.	Claims management and legislative standards	• The Claims Service Provider can demonstrate that it has the capability and capacity and is otherwise ready to manage claims in accordance with the Contract including claims management RACI, SIRA's customer service conduct principles and relevant NSW legislation.		[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]

No.	Deliverables	Acceptance Criteria	Evidence protocol	Date submitted for Acceptance	Milestone Date for Acceptance
		• All processes, procedures and icare operational material has been signed off and published.			
7.	People and capacity	• The Claims Service Provider has recruited and onboarded all roles required as at the end of the Transition-In Period with sufficient capacity to manage the anticipated claims volume.	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]
		• The Claims Service Provider has monitoring in place to assess resourcing requirements in the 12 month period following the end of the Transition-In Period.			
		• In relation to fraud management: ○ 6 months before the end of the Transition-In Period: the Claims Service Provider has requirements captured in the Transition-In Plan. ○ 3 months before the end of the Transition-In Period: the Claims Service Provider has resources in place (at minimum the leader). ○ Within 12 months of the end of the Transition-In Period: the Claims Service Provider has all resources and documentation in place.			

No.	Deliverables	Acceptance Criteria	Evidence protocol	Date submitted for Acceptance	Milestone Date for Acceptance
8.	Training and capability	• The Claims Service Provider's learning and development team has been equipped with all required training collateral. • All required roles have completed training and have the capability to manage claims following the end of the Transition-In Period.	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]
9.	Communications and email	• All collateral for customers has been created, signed off and is ready to be sent to customers as required. • Email has been tested and dedicated mailboxes established for Claims Service Provider correspondence.	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]
10.	Operational Reporting	• Qlik operational reports, which filter Claims Service Provider results separately via the security zone, are completed, tested and available to the Claims Service Provider and icare users. • The Claims Service Provider is equipped to utilise reports and has demonstrated an adequate understanding of how they will be used in operations.	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]
11.	Regulatory reporting and data quality	• Claims Service Provider has access and the capability to ensure that data quality issues are addressed as part of	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]

No.	Deliverables	Acceptance Criteria	Evidence protocol	Date submitted for Acceptance	Milestone Date for Acceptance
		icare's CDR submission and has confirmed that it is ready to submit claim files as part of icare's submission.			
12.	Customer	• Relevant stakeholders have been informed of the Claims Service Provider. • Claims Service Provider team members are ready and able to support corporate customers eligible for choice (if applicable). • The Claims Service Provider has demonstrated that it understands and can action employer transfer requests and and/or claim transfers as part of market share allocation in the new environment (if applicable).	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]
13.	Finance	• The Claims Service Provider's team has demonstrated that is aware of the operational finance requirements and has relevant access to Corporate Online and Payments Plus ready for operations.	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]
14.	Scenario testing / Dress rehearsal	• Design of a comprehensive plan to conduct operational scenario testing has been completed and all test cases prepared and agreed.	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]

No.	Deliverables	Acceptance Criteria	Evidence protocol	Date submitted for Acceptance	Milestone Date for Acceptance
		• A process has been established to identify and remediate defects identified during the Transition-In Period including a process to develop and implement manual workarounds.			
15.	Go-live support / hypercare	• An escalation process has been established and ongoing monitoring and reporting has been designed and implemented to support embedment and handover to BAU. • The Claims Service Provider is set up to continue to deliver beyond the program with ongoing contacts established and ability to scale (if applicable).	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]	[To be agreed by the Transition-In working group]

Signing page follows

Executed as an agreement

Richard Harding and Mary Maini execute the agreement as authorised representatives for and on behalf of **Insurance and Care NSW (ABN 16 759 382 489)** in its own right and acting for the **Workers Compensation Nominal Insurer** (**ABN 83 564 379 108**).