THE BOARD OF SUPERVISORS OF THE COUNTY OF STANISLAUS
BOARD ACTION SUMMARY

DEPT: CEO - Risk Management

BOARD AGENDA:5.B.2
AGENDA DATE: May 22, 2018

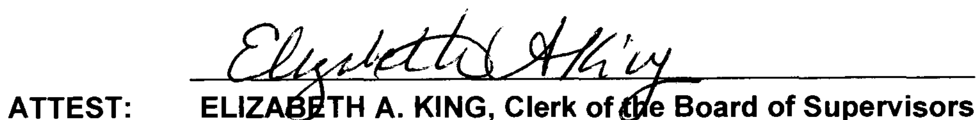
SUBJECT:
Approval of Agreement with Pegasus Risk Management, Inc. for Workers' Compensation Third Party Administrator Services for the Period of July 1, 2018 through June 30, 2021

BOARD ACTION AS FOLLOWS: **RESOLUTION NO. 2018-0232**

On motion of Supervisor Monteith **Seconded by Supervisor** Chiesa
and approved by the following vote,
Ayes: Supervisors: Chiesa, Monteith, and Chairman DeMartini
Noes: Supervisors: None
Excused or Absent: Supervisors: Olsen
Abstaining: Supervisor: Withrow

1) X **Approved as recommended**
2) ______ **Denied**
3) ______ **Approved as amended**
4) ______ **Other:**

MOTION:



ATTEST: **ELIZABETH A. KING, Clerk of the Board of Supervisors** **File No.**

THE BOARD OF SUPERVISORS OF THE COUNTY OF STANISLAUS
AGENDA ITEM

DEPT: CEO - Risk Management BOARD AGENDA:5.B.2
AGENDA DATE: May 22, 2018

CONSENT: ☑

CEO CONCURRENCE: YES 4/5 Vote Required: No

SUBJECT:

Approval of Agreement with Pegasus Risk Management, Inc. for Workers' Compensation Third Party Administrator Services for the Period of July 1, 2018 through June 30, 2021

STAFF RECOMMENDATION:

1. Approve an agreement with Pegasus Risk Management, Inc. of Modesto California, for Workers' Compensation Third Party Administrator Services for the period of July 1, 2018 through June 30, 2021.

2. Authorize the Purchasing Agent to sign the agreement and any future amendments based on changes in the volume of claims or legislative changes impacting services as permitted under the agreement.

DISCUSSION:

Stanislaus County currently contracts with York Risk Services Group, Inc. (York) for Workers' Compensation third party administrator services. The standard term for such an agreement is three years; however, the agreement was extended per Board of Supervisors' approval for two additional one-year terms based on the excellent service and performance outcomes provided by York. The existing agreement with York originally became effective July 1, 2013, and is set to expire on June 30, 2018.

York has proven to be a highly effective partner, producing the following results during its tenure as the County's third party administrator:

- Claim Closing Ratio – 128% average closing ratio since the start of the program in 2013
- Decrease in open inventory by more than 11% (Fiscal Years 2012/2013 - 2016/2017)
- Subrogation recovery for the life of the program is $62,840
- Utilization Review Savings of $656,640 (Fiscal Year 2013/2014 – 2016/2017)
- Consistent with industry best practices, bill review savings of $11,255,015 (Fiscal Years 2013/2014 – 2016/2017)
    - Average annual savings of $2,813,754

The close interaction between the County Chief Executive Office (CEO) – Risk Management Division team and the York claims team has played a key role in managing the financial exposures to the County and ultimately controlling overall claim costs.

To ensure that the County is continuing to receive the best available services at an affordable cost, the General Services Agency (GSA) Purchasing Division and the CEO - Risk Management Division conducted a Request for Proposal (RFP) in late 2017. The GSA advertised the RFP on Public Purchase, the GSA Purchasing's web-based posting website, and notified an additional 47 qualified bidders. A total of 19 vendors downloaded the RFP from the website and five responded with qualified bids: Athens Administrators, Inc.; Intercare Holdings Insurance Services; Pegasus Risk Management, Inc.; Tristar Risk Management; and York Risk Services Group, Inc.

County CEO - Risk Management Division staff convened a qualified five-person Evaluation Committee (EC) consisting of both County and experienced outside agency employees that was supervised by GSA. Working in concert with GSA, the EC engaged in a multi-phase evaluation process to arrive at the highest scored bidder, Pegasus Risk Management, Inc. (See Figure 1). It should be noted that there were no protests received during the five-day protest period nor anytime thereafter.

STANISLAUS COUNTY GENERAL SERVICES AGENCY - PURCHASING DIVISION
EVALUATION SUMMARY FOR RFP 17-67-CB
Figure 1

		TOTAL AVAILABLE	Athens	Intercare	Pegasus	Tristar	York
Phase I	Financial	N/A (PASS/FAIL)	P	P	P	P	P
Phase II	Proposal	100	93.50	94.10	90.70	87.20	96.70
Phase III	References/Audits	50	43.90	45.21	46.55	46.16	41.03
Phase IV	Presentation & Interview	50	48.00	45.55	43.15	43.90	47.50
Phase V	Pricing	100	78.83	75.39	100.00	80.57	87.88
TOTAL SCORE:		300.0	264.23	260.25	280.40	257.83	273.11

Pegasus Risk Management, Inc. (Pegasus) had the lowest pricing and also scored the highest in customer references and regulatory third-party audits. This positive customer feedback and validation of Pegasus' quality work provides confidence for the County in this transition. Pegasus also conducts bill reviews consistent with industry best practices and the County can expect the same high level of performance experienced with the prior vendor. Upon Board approval of the agreement, staff from the CEO - Risk Management Division, York, and Pegasus will work closely together to seamlessly transition the administration of the County's Workers' Compensation Program by the July 1, 2018, agreement commencement date.

POLICY ISSUE:

Current County policy and Government Code section 23005 and 25502.5 require Board of Supervisors' approval for all contracts exceeding $100,000. Approval of the proposed agreement with Pegasus Risk Management, Inc. will support ongoing administration and regulatory compliance of the County's Workers' Compensation Program.

FISCAL IMPACT:

The recommended agreement with Pegasus Risk Management, Inc. will total $1,693,426 in administrative costs over the three-year period, with $558,796 projected for year one, $567,315 for year two, and $567,315 for year three. The 2017-2018 Adopted Final Budget includes Workers' Compensation third party administrator services at an estimated $583,971 for the year. The cost of the recommended Pegasus contract will be included in the 2018-2019 Proposed Budget at an estimated $558,796 for the first year. Future year contract costs will be included in the appropriate upcoming budget cycles for consideration by the Board of Supervisors. The Workers' Compensation Program is funded by revenue from County departments and benefitting outside agencies based on departmental risk exposure (number of employees) and prior claims history. The projected administrative fees are included in the allocation of the annual Risk Management Division's Workers' Compensation Cost Allocation Plan (CAP) charges. There is no additional cost to the County General Fund beyond the annual Net County Cost approved as part of the budget process.

BOARD OF SUPERVISORS' PRIORITY:

The recommended actions are consistent with the Board's priorities of *Delivering Efficient Public Services and Community Infrastructure* by ensuring that proper administrative processes and protocols are in place to safeguard County employees injured on the job and that those employees will receive the services they need in a timely and cost-efficient manner.

STAFFING IMPACT:

There is no staffing impact associated with this agreement. Staff from the Chief Executive Office and CEO - Risk Management Division will continue to work closely with Pegasus Risk Management, Inc. staff to provide ongoing management and oversight of the County's Workers' Compensation Program.

CONTACT PERSON:

Patrice Dietrich, Assistant Executive Officer Telephone: (209) 525-6333

ATTACHMENT(S):

1. Pegasus, Risk Management, Inc. Workers' Compensation Program TPA Services

AGREEMENT
FOR
PROFESSIONAL SERVICES

This Agreement for Professional Services is made and entered into by and between the County of Stanislaus ("County") and Pegasus Risk Management, a California corporation ("Consultant"), as of July 1, 2018 (the "Agreement").

Introduction

WHEREAS, the County has a need for services involving workers' compensation claims administration and medical management; and

WHEREAS, the Consultant is specially trained, experienced and competent to perform and has agreed to provide such services; and

NOW, THEREFORE, in consideration of the mutual promises, covenants, terms and conditions hereinafter contained, the parties hereby agree as follows:

Terms and Conditions

1. Scope of Work

1.1 The Consultant shall furnish to the County upon execution of this Agreement or receipt of the County's written authorization to proceed, those services and work set forth in **Exhibit A**, ("Services") which is attached hereto and, by this reference, made a part hereof.

1.2 Any interest, including copyright interests, of Consultant or its contractors or subconsultants in studies, reports, memoranda, computational sheets, drawings, plans or any other documents, including electronic data, prepared in connection with the Services, shall be the property of County. To the extent permitted by law, work product produced under this Agreement shall be deemed works for hire and all copyrights in such works shall be the property of the County. In the event that it is ever determined that any works created by Consultant or its subconsultants under this Agreement are not works for hire, Consultant hereby assigns to County all copyrights to such works. With the County's prior written approval, Consultant may retain and use copies of such works for reference and as documentation of experience and capabilities. Should the County desire to reuse the documents specified above and not use the services of the Consultant, then the County agrees to require the new consultant to assume any and all obligations for the reuse of the documents, and the County releases Consultant and its subconsultants from all liability associated with the reuse of such documents.

1.3 Services and work provided by the Consultant under this Agreement will be performed in a timely manner in accordance with a schedule of work set forth in Exhibit A. If there is no schedule, the hours and times for completion of said services and work are to be set by the Consultant; provided, however, that such schedule is subject to review by and concurrence of the County.

1.4 The Consultant shall provide services and work under this Agreement consistent with the requirements and standards established by applicable federal, state and County laws, ordinances, regulations and resolutions. The Consultant represents and warrants that it will perform its work in accordance with generally accepted industry standards and practices for the profession or professions that are used in performance of this Agreement and that are in effect at the time of performance of this Agreement. Except for that representation and any representations made or contained in any proposal submitted by the Consultant and any reports or opinions prepared or issued as part of the work performed by the Consultant under this Agreement, Consultant makes no other warranties, either express or implied, as part of this Agreement.

1.5 If the Consultant deems it appropriate to employ a consultant, expert or investigator in connection with the performance of the services under this Agreement, the Consultant will so advise the County and seek the County's prior approval of such employment. Any consultant, expert or investigator employed by the Consultant will be the agent of the Consultant not the County.

2. Consideration

2.1 The Consultant shall be compensated on either a time and materials basis or a lump sum basis, as provided in Exhibit A attached hereto.

2.2 Except as expressly provided in this Agreement, Consultant shall not be entitled to nor receive from County any additional consideration, compensation, salary, wages or other type of remuneration for services rendered under this Agreement, including, but not limited to, meals, lodging, transportation, drawings, renderings or mockups. Specifically, Consultant shall not be entitled by virtue of this Agreement to consideration in the form of overtime, health insurance benefits, retirement benefits, disability retirement benefits, sick leave, vacation time, paid holidays or other paid leaves of absence of any type or kind whatsoever.

2.3 The Consultant shall provide the County with a monthly or a quarterly statement, as services warrant, of fees earned and costs incurred for services provided during the billing period, which the County shall pay in full within 30 days of the date each invoice is approved by the County. The statement will generally describe the services performed, the applicable rate or rates, the basis for the calculation of fees, and a reasonable itemization of costs. All invoices for services provided shall be forwarded in the same manner and to the same person and address that is provided for service of notices herein.

2.4 County will not withhold any Federal or State income taxes or Social Security tax from any payments made by County to Consultant under the terms and conditions of this Agreement. Payment of all taxes and other assessments on such sums is the sole responsibility of Consultant. County has no responsibility or liability for payment of Consultant's taxes or assessments.

3. Term

3.1 The term of this Agreement shall be from July 1, 2018 through June 30, 2021 unless sooner terminated as provided below or unless some other method or time of expiration is listed in Exhibit A.

3.2 Should either party default in the performance of this Agreement or materially breach any of its provisions, the other party, at that party's option, may terminate this Agreement by giving written notification to the other party.

3.3 The County may terminate this agreement upon 30 days prior written notice. Termination of this Agreement shall not affect the County's obligation to pay for all fees earned and reasonable costs necessarily incurred by the Consultant as provided in Paragraph 2 herein, subject to any applicable setoffs.

3.4 This Agreement shall terminate automatically on the occurrence of (a) bankruptcy or insolvency of either party, or (b) sale of Consultant's business.

4. Required Licenses, Certificates and Permits and Compliance with Laws

Any licenses, certificates or permits required by the federal, state, county or municipal governments for Consultant to provide the services and work described in Exhibit A must be procured by Consultant and be valid at the time Consultant enters into this Agreement. Further, during the term of this Agreement, Consultant must maintain such licenses, certificates and permits in full force and effect. Licenses, certificates and permits may include but are not limited to driver's licenses, professional licenses or certificates and business licenses. Such licenses, certificates and permits will be procured and maintained in force by Consultant at no expense to the County.

Consultant shall comply will all applicable local state and Federal Laws rules and regulations.

5. Office Space, Supplies, Equipment, Etc.

Unless otherwise provided in this Agreement, Consultant shall provide such office space, supplies, equipment, vehicles, reference materials and telephone service as is necessary for Consultant to provide the services under this Agreement. The Consultant--not the County--has the sole responsibility for payment of the costs and expenses incurred by Consultant in providing and maintaining such items.

6. Insurance

Coverage Required: Consultant shall obtain, and maintain at all times during the term of this Agreement, insurance coverage in the amounts and coverage specified in the attached "EXHIBIT B."

7. Defense and Indemnification

7.1 To the fullest extent permitted by law, Consultant shall indemnify, hold harmless and defend the County and its agents, officers and employees from and against all claims, damages, losses, judgments, liabilities, expenses and other costs, including litigation costs and attorneys' fees, arising out of, resulting from, or in connection with the performance of this Agreement by the Consultant or Consultant's officers, employees, agents, representatives or subcontractors and resulting in or attributable to personal injury, death, or damage or destruction to tangible or intangible property, including the loss of use. Notwithstanding the foregoing, Consultant's obligation to indemnify the County and its agents, officers and employees for any judgment, decree or arbitration award shall extend only to the percentage of negligence or responsibility of the Consultant in contributing to such claim, damage, loss and expense.

7.2 Consultant's obligation to defend, indemnify and hold the County and its agents, officers and employees harmless under the provisions of this paragraph is not limited to or restricted by any requirement in this Agreement for Consultant to procure and maintain a policy of insurance.

7.3 To the fullest extent permitted by law, the County shall indemnify, hold harmless and defend the Consultant and its officers, employees, agents, representatives or subcontractors from and against all claims, damages, losses, judgments, liabilities, expenses and other costs, including litigation costs and attorney's fees, arising out of or resulting from the negligence or wrongful acts of County and its officers or employees.

7.4 Subject to the limitations in 42 United States Code section 9607 (e), and unless otherwise provided in a Scope of Services approved by the parties:

(a) Consultant shall not be responsible for liability caused by the presence or release of hazardous substances or contaminants at the site, unless the release results from the negligence of Consultant or its subcontractors;

(b) No provision of this Agreement shall be interpreted to permit or obligate Consultant to assume the status of "generator," "owner," "operator," "arranger," or "transporter" under state or federal law; and

(c) At no time, shall title to hazardous substances, solid wastes, petroleum contaminated soils or other regulated substances pass to Consultant.

8. Status of Consultant

8.1 All acts of Consultant and its officers, employees, agents, representatives, subcontractors and all others acting on behalf of Consultant relating to the performance of this Agreement, shall be performed as independent contractors and not as agents, officers or employees of County.

Consultant, by virtue of this Agreement, has no authority to bind or incur any obligation on behalf of County. Except as expressly provided in Exhibit A, Consultant has no authority or responsibility to exercise any rights or power vested in the County. No agent, officer or employee of the County is to be considered an employee of Consultant. It is understood by both Consultant and County that this Agreement shall not be construed or considered under any circumstances to create an employer-employee relationship or a joint venture.

8.2 At all times during the term of this Agreement, the Consultant and its officers, employees, agents, representatives or subcontractors are, and shall represent and conduct themselves as, independent contractors and not employees of County.

8.3 Consultant shall determine the method, details and means of performing the work and services to be provided by Consultant under this Agreement. Consultant shall be responsible to County only for the requirements and results specified in this Agreement and, except as expressly provided in this Agreement, shall not be subjected to County's control with respect to the physical action or activities of Consultant in fulfillment of this Agreement. Consultant has control over the manner and means of performing the services under this Agreement. If necessary, Consultant has the responsibility for employing other persons or firms to assist Consultant in fulfilling the terms and obligations under this Agreement.

8.4 Consultant is permitted to provide services to others during the same period service is provided to County under this Agreement; provided, however, such services do not conflict directly or indirectly with the performance of the Consultant's obligations under this Agreement.

8.5 If in the performance of this Agreement any third persons are employed by Consultant, such persons shall be entirely and exclusively under the direction, supervision and control of Consultant. All terms of employment including hours, wages, working conditions, discipline, hiring and discharging or any other term of employment or requirements of law shall be determined by the Consultant.

8.6 It is understood and agreed that as an independent contractor and not an employee of County, the Consultant and the Consultant's officers, employees, agents, representatives or subcontractors do not have any entitlement as a County employee, and, except as expressly provided for in any Scope of Services made a part hereof, do not have the right to act on behalf of the County in any capacity whatsoever as an agent, or to bind the County to any obligation whatsoever.

8.7 It is further understood and agreed that Consultant must issue W-2 forms or other forms as required by law for income and employment tax purposes for all of Consultant's assigned personnel under the terms and conditions of this Agreement.

8.8 As an independent contractor, Consultant hereby indemnifies and holds County harmless from any and all claims that may be made against County based upon any contention by any third party that an employer-employee relationship exists by reason of this Agreement.

9. Records and Audit

9.1 Consultant shall prepare and maintain all writings, documents and records prepared or compiled in connection with the performance of this Agreement for a minimum of four (4) years from the termination or completion of this Agreement. This includes any handwriting, typewriting, printing, photostatic, photographing and every other means of recording upon any tangible thing, any form of communication or representation including letters, words, pictures, sounds or symbols or any combination thereof.

9.2 Any authorized representative of County shall have access to any writings as defined above for the purposes of making audit, evaluation, examination, excerpts and transcripts during the period such records are to be maintained by Consultant. Further, County has the right at all reasonable times to audit, inspect or otherwise evaluate the work performed or being performed under this Agreement.

10. Confidentiality

The Consultant shall keep confidential all information obtained or learned during the course of furnishing services under this Agreement and to not disclose or reveal such information for any purpose not directly connected with the matter for which services are provided.

11. Nondiscrimination

11.1 During the performance of this Agreement, Consultant and its officers, employees, agents, representatives or subcontractors shall not unlawfully discriminate in violation of any Federal, State or local law, rule or regulation against any employee, applicant for employment or person receiving services under this Agreement because of race, religious creed, color, national origin, ancestry, physical or mental disability including perception of disability, medical condition, genetic information, pregnancy related condition, marital status, gender/sex, sexual orientation, gender identity, gender expression, age (over 40), political affiliation or belief, or military and veteran status. Consultant and its officers, employees, agents, representatives or subcontractors shall comply with all applicable Federal, State and local laws and regulations related to non-discrimination and equal opportunity, including without limitation the County's non-discrimination policy; the Fair Employment and Housing Act (Government Code sections 12900 et seq.); California Labor Code sections 1101 and 1102; the Federal Civil Rights Act of 1964 (P.L. 88-352), as amended; and all applicable regulations promulgated in the California Code of Regulations or the Code of Federal Regulations.

11.2 Consultant shall include the non-discrimination and compliance provisions of this clause in all subcontracts to perform work under this Agreement.

11.3 Consultant shall provide a system by which recipients of service shall have the opportunity to express and have considered their views, grievances, and complaints regarding Consultant's delivery of services.

12. Assignment

This is an agreement for the services of Consultant. County has relied upon the skills, knowledge, experience and training of Consultant and the Consultant's firm, associates and employees as an inducement to enter into this Agreement.

Consultant shall not assign or subcontract this Agreement without the express written consent of County. Further, Consultant shall not assign any monies due or to become due under this Agreement without the prior written consent of County.

13. Waiver of Default

Waiver of any default by either party to this Agreement shall not be deemed to be waiver of any subsequent default. Waiver or breach of any provision of this Agreement shall not be deemed to be a waiver of any other or subsequent breach, and shall not be construed to be a modification of the terms of this Agreement unless this Agreement is modified as provided below.

14. Notice

Any notice, communication, amendment, addition or deletion to this Agreement, including change of address of either party during the term of this Agreement, which Consultant or County shall be required or may desire to make shall be in writing and shall be personally served or, alternatively, sent by prepaid first class mail to the respective parties as follows:

To County:	To Consultant:
CEO Risk Management Division	Pegasus Risk Management, Inc.
1010 10th Street, Suite 5900	PO Box 5038
Modesto, CA 95354	Modesto, CA 95352
Manager of Safety and Disability	Attn: Jeff Simon

15. Conflicts

Consultant agrees that it has no interest and shall not acquire any interest direct or indirect which would conflict in any manner or degree with the performance of the work and services under this Agreement.

16. Severability

If any portion of this Agreement or application thereof to any person or circumstance shall be declared invalid by a court of competent jurisdiction or if it is found in contravention of any federal, state or county statute, ordinance or regulation the remaining provisions of this Agreement or the application thereof shall not be invalidated thereby and shall remain in full force and effect to the extent that the provisions of this Agreement are severable.

17. Amendment

This Agreement may only be modified, amended, changed, added to or subtracted from by the mutual consent of the parties hereto if such amendment or change is in written form and executed with the same formalities as this Agreement and attached to the original Agreement to maintain continuity.

18. Entire Agreement

This Agreement supersedes any and all other agreements, either oral or in writing, between any of the parties herein with respect to the subject matter hereof and contains all the agreements between the parties with respect to such matter. Each party acknowledges that no representations, inducements, promises or agreements, oral or otherwise, have been made by any party, or anyone acting on behalf of any party, which are not embodied herein, and that no other agreement, statement or promise not contained in this Agreement shall be valid or binding.

19. Advice of Attorney

Each party warrants and represents that in executing this Agreement, it has received independent legal advice from its attorneys or the opportunity to seek such advice.

20. Construction

Headings or captions to the provisions of this Agreement are solely for the convenience of the parties, are not part of this Agreement, and shall not be used to interpret or determine the validity of this Agreement. Any ambiguity in this Agreement shall not be construed against the drafter, but rather the terms and provisions hereof shall be given a reasonable interpretation as if both parties had in fact drafted this Agreement.

21. Governing Law and Venue

This Agreement shall be deemed to be made under, and shall be governed by and construed in accordance with, the laws of the State of California. Any action brought to enforce the terms or provisions of this Agreement shall have venue in the County of Stanislaus, State of California.

22. Incorporation of Performance Standards

22.1 All claims administration services performed by TPA shall comply with those provisions set forth in the CSAC EIA Workers' Compensation Claims Administration Guidelines attached hereto as EXHIBIT D and incorporated herein as though fully set forth. Should the attached Standards be amended, during the term of the Agreement, Such amendments shall be deemed to be incorporated herein.

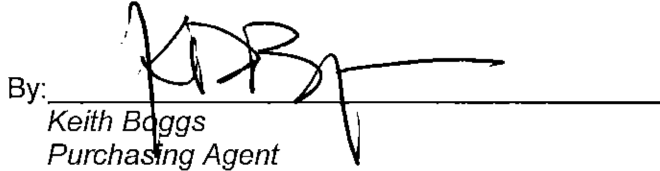
22.2 TPA shall comply with the SCOPE of work as provided in the County's Request for Proposal including a maximum case load of 150 indemnity claims.

22.3 Additionally, the compensation for claims administration services may be adjusted according to the Performance Based Contract Provision, attached hereto as Exhibit F and incorporated herein as though fully set forth during the term of the Agreement, Such amendments shall be deemed to be incorporated herein.

[SIGNATURES SET FORTH ON THE FOLLOWING PAGE]

IN WITNESS WHEREOF, the parties or their duly authorized representatives have executed this Agreement on the day and year first hereinabove written.

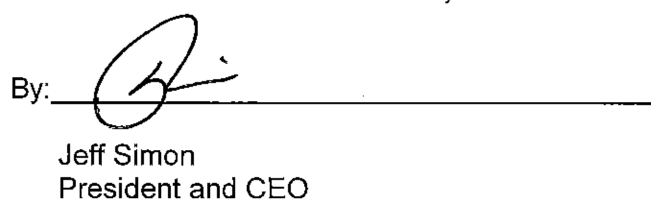
COUNTY OF STANISLAUS



By:____________________________
Keith Boggs
Purchasing Agent

"County"

PEGASUS RISK MANAGEMENT, INC.



By:____________________________
Jeff Simon
President and CEO

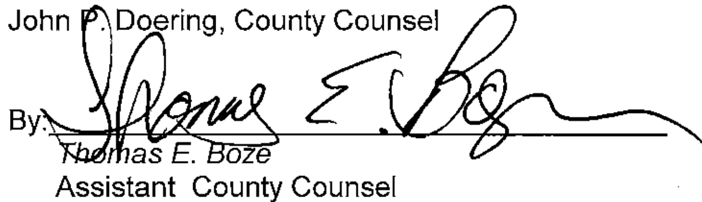
"Consultant"

BOS# 2018-0232

APPROVED AS TO CONTENT:

By:____________________________
Patrice Dietrich
Assistant Executive Officer

APPROVED AS TO FORM:
John P. Doering, County Counsel



By:____________________________
Thomas E. Boze
Assistant County Counsel

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EXHIBIT A

A. SCOPE OF WORK

The Consultant shall provide services under this Agreement for Professional Services between the County of Stanislaus and Pegasus Risk Management ("Consultant"), as set forth in the Consultant's Proposal and Scope of Work dated January 4, 2018 (EXHIBIT C), and the California State Association of Counties Excess Insurance Authority (CSAC EIA) Addendum A, (EXHIBIT D).

1. Schedule and Budget

Consultant shall complete the report on a mutually acceptable schedule. Consultant fee schedule is identified in EXHIBIT E. Consultant shall only bill for work completed and not in work in progress, except nurse case management work, which shall be billed monthly. However, billing monthly for ongoing work of nurse case management shall be an exception.

B. COMPENSATION

The Consultant shall be compensated for the services provided under this Agreement as follows:

1. Consultant will be compensated on a time and materials basis, not to exceed the limit of in Paragraph 2 below, based on the hours worked by the Consultant's employees or subcontractors at the hourly rates specified in the consultant's Proposal. The specified hourly rates shall include direct salary costs, employee benefits, and overhead. These rates are not adjustable for the performance period set forth in this Agreement. In addition to the aforementioned fees, Consultant will be reimbursed for the following items, plus any expenses agreed by the parties as set forth in the Consultant's Proposal attached hereto, that are reasonable, necessary and actually incurred by the Consultant in connection with the services. Travel expenses shall be in accordance with the County's Travel policy, herein incorporated by reference. No markup shall be paid on reimbursed items.

   (a) Any filing fees, permit fees, or other fees paid or advanced by the Consultant.

   (b) Expenses, fees or charges for printing, reproduction or binding of documents at actual costs.

2. The parties hereto acknowledge the maximum amount to be paid by the County for services provided shall not exceed $1,693,426, including, without limitation, the cost of any subcontractors, consultants, experts or investigators retained by the Consultant to perform or to assist in the performance of its work under this Agreement.

C. TERM

Paragraph 3.1 of the body of this Agreement is amended to read as follows:

3.1 This agreement will not automatically renew but may be renewed for two (2) one-year terms by mutual written agreement of the parties. In no case shall the renewal extend beyond June 30, 2023.

D. PERFORMANCE BASED CONTRACT PROVISIONS

The Consultant shall adhere to the Performance Based Contract Provisions, as set forth in the Performance Based Contract provision-TPA (EXHIBIT F), attached hereto and, by this reference, made a part hereof.

E. INVOICE TO:

Invoices shall be submitted to:

Chief Executive Office – Risk Management 1010 10th Street, Suite 5900 Modesto, CA 95354 Attn: Accounts Payable

Exhibit B

Insurance Requirements for Workers Compensation Third Party Administrator

Consultant shall procure and maintain for the duration of the contract insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder by the Consultant, its agents, representatives, or employees.

MINIMUM SCOPE AND LIMIT OF INSURANCE
Coverage shall be at least as broad as:

1. **Commercial General Liability** (CGL): Insurance Services Office Form CG 00 01 covering CGL on an "occurrence" basis, including products and completed operations, property damage, bodily injury and personal & advertising injury with limits no less than $2,000,000 per occurrence. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this project/location (ISO CG 25 03 or 25 04) or the general aggregate limit shall be twice the required occurrence limit.
2. **Automobile Liability**: If the Consultant or the Consultant's officers, employees, agents, representatives or subcontractors utilize a motor vehicle in performing any of the work or services under the Agreement Insurance Services Office Form Number CA 0001 covering, Code 1 (any auto), or if Consultant has no owned autos, Code 8 (hired) and 9 (non-owned), with limit no less than $1,000,000 per accident for bodily injury and property damage.
3. **Workers' Compensation** insurance as required by the State of California, with Statutory Limits, and Employer's Liability Insurance with limit of no less than $1,000,000 per accident for bodily injury or disease.
4. **Professional Liability** (Errors and Omissions) Insurance appropriates to the Consultant's profession, with limits not less than $2,000,000 per occurrence or claim, $4,000,000 aggregate.
5. **Cyber Liability** Insurance, with limits not less than $2,000,000 per occurrence or claim, $2,000,000 aggregate. Coverage shall be sufficiently broad to respond to the duties and obligations as is undertaken by Vendor in this agreement and shall include, but not be limited to, claims involving infringement of intellectual property, including but not limited to infringement of copyright, trademark, trade dress, invasion of privacy violations, information theft, damage to or destruction of electronic information, release of private information, alteration of electronic information, extortion and network security. The policy shall provide coverage for breach response costs as well as regulatory fines and penalties as well as credit monitoring expenses with limits sufficient to respond to these obligations.
6. **Third Party Crime** insurance with a minimum limit of $1,000,000, naming The County, its officers, officials, employees, agents and volunteers as an additional insured or as a loss payee, to protect the county and employees from loss due to the actions of the claims administrator, its agents, owners, officers and employees of the criminal actions of third parties.

If the Consultant maintains broader coverage and/or higher limits than the minimums shown above, the County requires and shall be entitled to the broader coverage and/or higher limits maintained by the Consultant. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to the County.

Application of Excess Liability Coverage
Consultants may use a combination of primary, and excess insurance policies which provide coverage as broad as ("follow form" over) the underlying primary policies, to satisfy the Required Insurance provisions.

Other Insurance Provisions
The insurance policies are to contain, or be endorsed to contain, the following provisions:

Additional Insured Status
The County, its officers, officials, employees, agents and volunteers are to be covered as additional insureds on the CGL and the Auto policy with respect to liability arising out of work or operations performed by or on behalf of the Consultant including materials, parts, or equipment furnished in connection with such work or operations. General liability and Auto Liability coverage can be provided in the form of an endorsement to the Consultant's insurance (**at least** as broad as ISO Form CG 20 10 11 85 or **both** CG 20 10, CG 20 26, CG 20 33, or CG 20 38; **and** CG 20 37 forms if later revisions used).

Primary Coverage
For any claims related to this contract, the **Consultant's insurance coverage shall be primary** insurance primary coverage **at least** as broad as ISO CG 20 01 04 13 as respects the County, its officers, officials, employees, agents and volunteers. Any insurance or self-insurance maintained by the County, its officers, officials, employees, agents or volunteers shall be excess of the Consultant's insurance and shall not contribute with it.

Reporting: Any failure to comply with reporting provisions of the policies shall not affect coverage provided to the County or its officers, officials, employee's, agents or volunteers.

Notice of Cancellation
Each insurance policy required above shall state that **coverage shall not be canceled, except with notice to the County.**

Waiver of Subrogation
Consultant hereby grants to County a waiver of any right to subrogation (except for Professional Liability) which any insurer of said Consultant may acquire against the County by virtue of the payment of any loss under such insurance. Consultant agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the County has received a waiver of subrogation endorsement from the insurer.

Self-Insured Retentions
Self-insured retentions must be declared to and approved by the County. The County may require the Consultant to provide proof of ability to pay losses and related investigations, claim administration,

and defense expenses within the retention. The policy language shall provide, or be endorsed to provide, that the self-insured retention may be satisfied by either the named insured or County.

Acceptability of Insurers
Insurance is to be placed with California admitted insurers (licensed to do business in California) with a current A.M. Best's rating of no less than A-VII, however, if no California admitted insurance company provides the required insurance, it is acceptable to provide the required insurance through a United States domiciled carrier that meets the required Best's rating and that is listed on the current List of Approved Surplus Line Insurers (LASLI) maintained by the California Department of Insurance.

Claims Made Policies
If any of the required policies provide coverage on a claims-made basis:
1. The Retroactive Date must be shown and must be before the date of the contract or the beginning of contract work.
2. Insurance must be maintained and evidence of insurance must be provided for **at least** five (5) years after completion of the contract of work.
3. If coverage is canceled or non-renewed, and not replaced with another claims-made policy form with a Retroactive Date prior to the contract effective date, the Consultant must purchase "extended reporting" coverage for a minimum of five (5) years after completion of contract work.

Verification of Coverage
Consultant shall furnish the County with a copy of the policy declaration and endorsement page(s), original certificates and amendatory endorsements or copies of the applicable policy language effecting coverage required by this clause. All **certificates and endorsements are to be received and approved by the County before work commences**. However, failure to obtain the required documents prior to the work beginning shall not waive the Consultant's obligation to provide them. The County reserves the right to require complete, certified copies of all required insurance policies, including endorsements required by these specifications, at any time.

Subcontractors
Consultant shall require and verify that all subcontractors maintain insurance meeting all the requirements stated herein, and Consultant shall ensure that County is an additional insured on insurance required from subcontractors.

Special Risks or Circumstances
County reserves the right to modify these requirements, including limits, based on the nature of the risk, prior experience, insurer, coverage, or other special circumstances.

Insurance Limits
The limits of insurance described herein shall not limit the liability of the Consultant and Consultant's officers, employees, agents, representatives or subcontractors. Consultant's obligation to defend, indemnify and hold the County, its officers, officials, employees, agents and volunteers harmless under the provisions of this paragraph is not limited to or restricted by any requirement in the Agreement for Consultant to procure and maintain a policy of insurance.

[SIGNATURES SET FORTH ON THE FOLLOWING PAGE]

_______ Exempt from Auto – I will not utilize a vehicle in the performance of my work with the County.

_______ Exempt from WC – I am exempt from providing workers' compensation coverage as required under section 1861 and 3700 of the California Labor Code.

I acknowledge the insurance requirements listed above.

Print Name: JEFF SIMON Date: 5/18/18

Signature: ______ Date: 5/18/18

Vendor Name: Pegasus Risk Management Inc.

For CEO-Risk Management Division use only

Exception: N/A

Approved by CEO-Risk Management Division: ______ Date: 5/17/2018

EXHIBIT C

SCOPE OF WORK

1. SERVICES

Services to be provided MUST include, but not be limited to:

1.1 Claims Administration of new and existing claims. The County's past three year claim average has been 109 new indemnity claims and 91 medical only claims per fiscal year.

1.2 Online real time access to all claims data including but not limited to:

1. Ability to access and input information for completion of the Form 5020 into an online system (NOTE: This system must generate a hardcopy of the form as well as populate the TPA's claim system database).

2. Ability to view claim payments.

3. Ability to view examiner's Plan of Action.

4. Ability to view claims disposition (accepted, denied, settled).

5. Ability to view list of authorized RX including date approved, dosage and applicable medical condition.

6. Ability to view claims settlement type; Stipulated Award, Compromise & Release, Findings & Award, etc.

7. Accurate tracking of lost time and associated payments (TTD, TPD, LC 4850).

8. Ability of County to run standard and ad hoc claim-related statistical reports (provide copies of reporting capability with RFP submission).

9. Ability to produce claim status reports including paid to date amounts by reserve type and outstanding reserve balances (NOTE: provide copy of status report with RFP submission).

10. Ability to view examiner notes.

11. Ability to view examiner's Diary Status.

12. Ability to view accepted and denied body parts.

13. Ability to view the litigation status, along with applicant and defense attorney contact information.

14. Ability to view staff of Contractor's assigned (i.e., Nurse Case Management, Investigators, etc.).

15. Ability to produce accurate OSHA reports on a monthly and annual basis.

1.3 Transition claims from current TPA provider, both electronic files and hard copy files. The Contractor must be able to begin claims administration on July 1, 2018 and must be able to avoid any late payments. The Contractor will identify time line for transition of all claim data, records and files.

1.4 Assist the County in submitting a revised Medical Provider Network. The County has an existing Medical Provider Network (Appendix F that the Contractor shall work with the County to mirror the existing providers and may make recommendations for additions or deletions to the existing network subject to the County's approval. The Contractor will be able to provide access to the current MPN providers through its existing PPO Networks.

If there are any physicians on the existing network that the Contractor does not currently have access to, the Contractor will notify the County in the RFP submission. The Contractor may make recommended changes to the Network in the RFP submission.

2. CLAIM MANAGEMENT

2.1 Each Claims Examiner shall (a) have a minimum of three years active claims adjusting experience as a claims examiner, (b) have a Self-Insured Competency Certificate and (c) maintain a case load of 150 open indemnity claims or less at all times. The County requests to have Claims Examiners (Claims Trainee or Assistant will not suffice) assigned exclusively to the County's account *, with availability to County staff during core business hours of 8:00 am to 5:00 pm Monday through Friday. It is preferred that a 1.5-to-1 ratio be maintained between Technical Assistance and Claims Examiners. Claims Examiners and support staff shall have direct supervision from a licensed supervisor and/or manager. *Two examiners shall be full time and assigned to the County exclusively. One examiner may be part time or be shared with another client. The County currently utilizes a department assignment for examiners and will approve all examiner department assignments.

2.2 Claim files shall be reviewed and set up within twenty-four (24) hours of receipt from the County. All new claims will be indexed through CSAC-EIA's index system upon setup and annually thereafter. Questionable claims will be delayed and promptly investigated. The County will be notified of the disposition of all new claims within forty-eight (48) hours of receipt of the claims. A completed signed medical release shall be obtained on all claim files.

2.3 If a doctor's first report of work injury is received without a corresponding claim, the examiner will immediately contact the County to determine if a new claim has occurred.

2.4 The Contractor proposer shall establish monetary reserves adequate for the expected compensation and medical benefits on each injury/claim file made up. A claims diary system to review the status of each injury/claim every twenty (20) to thirty (30) days will be adhered to by all examiners.

2.5 Claims with severe injuries or extended lost time require phone or personal contact with claimants shall occur within twenty-four (24) hours of receipt of claim, except in cases where employees are represented by an attorney. All other indemnity claims shall have contact with claimants within three (3) business days or less.

2.6 All claim files shall be available to the County, in person and on line, for inspection, review, and/or claims audit with or without prior notice to the adjusting firm. It is understood and agreed that all files will remain the property of Stanislaus County at all times.

2.7 All Claims Administration staff must be pre-approved by the County. The Contractor will provide the County with current resumes and past work experience history for the County's review prior to assigning staff to the County's account.

2.8 All claim decisions (deny/accept) require prior consultation and consideration by County's Risk Management Division.

2.9 The County must first approve settlement authority for claims before presented or negotiated with injured workers or their attorneys. The Contractor shall submit a written analysis of the case, including settlement options and recommendations to County's Risk Management Division at least ten (10) working days prior to settlement offers or conferences. The County must approve all settlement offers in excess of $5,000.

The County must be informed of all settlement offers below $5,000.

2.10 Claims personnel will utilize professional, Courteous, and empathetic communication skills at all times both verbally and in writing. Communication with the injured employee is to be available in the employee's primary language, or upon request by translation. The Claims Administrator will use disability accessible communication methods when requested.

3. COMPENSATION AND MEDICAL BENEFITS

3.1 The Contractor shall provide all compensation and medical benefits that may be due, in a timely manner in compliance with the statutory requirements of the California Labor Code and County expectations. All treatment plans should be reviewed and approved in accordance with Utilization Review criteria to determine if treatment is reasonable, necessary and appropriate based on readily accepted scientific medical evidence such as ACOEM or other nationally recognized and peer- reviewed scientific medical evidence.

3.2 Temporary Disability and LC 4850 benefit payments shall coincide with the County's payroll schedule.

3.2.1 All required benefit and informational notices shall be sent to the injured employees in a timely manner.

3.2.2 Estimates of permanent disability shall be provided to the County and defense counsel on all claims where PD benifis are anticipated or may be due.

3.2.3 Medical evaluations will be arranged when needed, reasonable, and/or requested. Copies of all medical reports and legal correspondence will be provided to the County within 24 hours of receipt. Access to electronic documents may replace the need to send hard copies. Notification of new documents must be provided within 24 hours of documents being received by the claims examiner.

3.2.4 Promptly pay all medical and other bills on the claims within the requirements of current California labor code statutes.

3.2.5 Reduce medical bills, other than medical legal expenses, to the Relative Value Schedule and recommended rates set by the Administrative Director, Division of Industrial Relations or based on PPO contracts that may apply.

3.3 Medical Control

3.3.1 Expedite obtaining signed medical release forms for all claims.

3.3.2 Administration of the County's existing Medical Provider Network (MPN), including monitoring medical treatment to allow changes through the MPN. Any changes to the MPN will require the County's final approval.

3.3.3 Monitor medical treatment for injured employees, including the review of all "Doctors First Report of Work Injury", to ensure that the treatment is related to a compensable injury or illness and complies with ACOEM and other nationally recognized and peer-reviewed scientific medical evidence guidelines.

3.3.4 Maintain close liaison with treating physicians to ensure that employees receive proper care, avoid over-treatment, and to assure physician compliance with Utilization Review standards.

3.3.5 The County has an aggressive Disability Management Program and will accommodate modified duty whenever possible. The Contractor must support and strengthen this program and assist the County in facilitating injured employees in returning to work, including modified duty options and expediting evaluations to determine the physical capabilities of all injured workers.

3.3.6 Maintain close working relationship with County's Risk Management Division, Disability Management Unit which includes the Manager, and the Disability Coordinators.

3.3.7 Provide medical reports in a timely manner including, but not limited to all reports of work restrictions, temporary or permanent from any and all physicians even if the report is not considered substantial evidence.

3.4 Employee Services

3.4.1 The workers compensation system is complicated and structured. Most employees who find themselves a part of the system have little grasp of how it works and what their obligations are. The Administrator shall take an active role in helping the employee by promptly answering questions and giving courteous and clear answers and direction. The Administrator will respond to inquiries on specific injuries and permanent disability ratings in accordance with the County's policies and the County's MPN.

3.4.2 Assist in resolving employee problems related to an industrial injury in non-litigated cases.

3.4.3 Recommend policies and procedures to ensure that the employee's ability to work is consistent with the findings of the Workers Compensation Appeals Board.

4. REHABILITATION, JOB DISPLACEMENT, LITIGATION & SUBROGATION

4.1 Job Displacement

4.1.1 Comply with labor code statutes and rules & regulations applicable to rehabilitation for workers' compensation injuries.

4.1.2 Provide injured employees Job Displacement vouchers in a timely manner and comply with the Labor Codes statutes and rules & regulations applicable to job displacement benefits for workers' compensation injuries.

4.1.3 Maintain adequate reserves on all claims where rehabilitation is an issue.

4.1.4 Prepare and submit the Division of Industrial Relations Rehabilitation forms as required by statute.

4.2 Litigation

4.2.1 Selection of defense counsel shall be approved by the County prior to an assignment being made. Investigations are to be coordinated with County staff.

4.2.2 Litigation effort shall be controlled and closely monitored by the administrator with regular communication with the County (copies, etc.)

4.2.3 Medical Control of litigated claims shall stay with the Administrator and shall not pass to defense counsel unless approved by the County.

4.2.4 The County staff must first approve settlement authority for claims before being presented or negotiated with injured workers and or their attorney(s). The Contractor shall submit a written analysis of the case, including settlement options and recommendations to County's Risk Management Division at least ten (10) working days prior to settlement offers or conferences. The County must approve all settlement offers in excess of $5,000. The County must be informed of all settlement offers below $5,000.

4.2.5 Claims examiners shall make an effort to settle claims without assignment to defense counsel whenever possible.

4.3 Subrogation

4.3.1 The Contractor shall identify and pursue subrogation opportunities in consultation with County's Risk Management Division.

4.4 Investigation

4.4.1 The use of investigators must be approved by the County prior to an assignment being made.

4.4.2 The Contractor shall investigate every claim using three-point contact, and recorded statements when appropriate. Recorded statements require prior approval of County's Risk Management Division.

4.4.3 The Contractor shall take an aggressive stance against fraud by filing the appropriate forms with the State Department of Insurance whenever warranted. The Contractor shall aggressively pursue fraud cases with the District Attorney's office when appropriate.

5. REPORTS AND REPORTING CAPABILITY

Contractor shall provide computerized loss analysis and summary reports each month covering activity on all newly reported, opened, and newly closed claims for the period. The report will be customized, as determined by the County, for County needs within the capability of the adjusting firm and, as a minimum, provide the following for claim year:

5.1 Excess Insurance Carrier Claims & Reports: The Contractor shall adhere to the County's excess insurance carrier claim reporting requirements (attached).

5.2 Actuary Reports: The Contractor shall provide reports and other requested data to actuarial firm at the County's request.

5.3 Daily Reports:
5.3.1 Check register in Excel format.

5.4 As Needed Reports: The Contractor shall provide within 5 business days when requested by the County the following reports to County's Risk Management Division electronically::

5.3.1 Status of all open claims with employees off on a disability or newly returned to work.

5.3.2 List of all employees being accommodated on modified duty including the current work restrictions.

5.3.3 Appearance, hearing, trial, and important date calendar.

5.3.4 Claims in "delay" status or newly accepted or denied claims.

5.3.6 All claims open by claim type.

5.3.7 Bill Review activity and associated savings.

5.3.8 Utilization Review referrals and decisions.

5.4 Monthly Reports: The Contractor shall provide at a minimum the following reports to County's Risk Management Division electronically on a monthly basis before the 10th day of each month:

5.4.1 Detailed report of all open claims (regardless of date of injury), including name, claim number, location, description of claim, injury and mechanism of injury, amounts paid, reserved and incurred for medical expense and indemnity.

5.4.2 All new claims opened during the month by department and location stating the claim number, claimant's name, cause and type of injury, body part, amount paid during the period to date and remaining reserves for medical, compensation, and any future allocated expense. Total amount incurred for each type of payment must also be shown.

5.4.3 All claims closed during the month by department and location stating the claim number, claimant's, name, cause and type of injury, body part, amount paid to date for medical, compensation, and any future allocated expense. Total amount incurred for each type of payment must also be shown.

5.4.4 Lag report listing all claims reported in the last month, by department and dates of knowledge and reporting dates.

5.4.5 Administrative reports containing number of claims, medical only, indemnity and first aid/incident; number of closed claims; number of active files assigned to each examiner; amount paid for medical, expense, and indemnity for each department, division or agency in: amount reserved for medial expense and indemnity for each agency; indemnity paid, 4850 benefits, Temporary Disability, Permanent Disability, Death Benefits, expenses paid for:, Nurse Case Management, Investigators, and attorneys; cases assigned to counsel, investigators, nurse case managers; amounts recovered in apportionment and subrogation; number of litigated cases; list of cases settled during the month, indicating the amount of the settlement and method of settlement (stipulations, C&R, dismissal, etc); penalties paid, including whether attributable to TPA or County; savings related to modified duty accommodations and ad hoc reports upon request.

5.4.6. Report claims accurately and timely including tracking for all claimants meeting mandatory Medicare reporting requirements per Medicare Secondary Payer and related statutes and provide associated data to the County.

5.4.7. Prepare and provide County's Risk Management Division with OSHA 300 report at the department and division levels to meet Cal-OSHA standards.

5.4.8. Prepare charts and graphs on a quarterly basis for statistical analysis of countywide claim frequency and severity as well as similar charts and graphs for the top five departments.

5.4.9 Provider summaries to include individual claims, number of visits, visit intervals and amounts paid.

5.4.10 Monthly check reconciliation reports.

5.4.11 Bill Review activity and associated savings.

5.4.12 Utilization Review referrals and decisions.

5.5 Quarterly Reports: The Contractor shall provide at a minimum the following reports to County's Risk Management Division electronically on a quarterly basis before the 10th day of the month ending the quarter:

5.5.1 Charts, graphs and supporting documents (include number of claims, paid to date and future reserves valued as of the end of the quarter) for Claims Filed by Year of Injury for past six (6) years (number of indemnity, medical only and first aid claims); Occupation most frequent, Cause of Loss Most Frequent, Paid Loss Days by Department, Modified Duty Savings by Department, Job Experience (number of years employed 1-5, 6-10, etc). Valuation for all charts and graphs that include prior years data are all valued as of the same date as the end of the quarter.

5.6 Annual Reports: The Contractor shall provide at a minimum the following reports to County's Risk Management Division on an annual basis by September 1st of each year;

5.6.1. Annual Self-Insured Report as required by the State of California.

5.6.2 Vendor report in spreadsheet format, listing amounts paid to each vendor.

5.6.3 1099 reports for each vendor.

5.6.4 OSHA 300 A report by department and division.

5.6.5 An annual report as of June 30th each fiscal year with loss trend analysis including charts, graphs and supporting reports.

5.6.6 Charts, graphs and supporting reports to assist Departments in the development of Departmental Action Plans.

5.6.7 Amounts paid for fiscal year valued as of year-end by Reserve Type. Amounts paid for prior five (5) fiscal years valued as of current year-end date by reserve type of year of injury.

5.6.8 Amounts paid during the fiscal year for all dates of injury valued as year-end by Department/Division/Unit.

6. OTHER SERVICES

6.1 At the sole discretion of the County, examiners attendance at Workers' Compensation Appeals Board Hearings, rehabilitation conferences, conferences with legal counsel (defense counsel), meeting with County staff, departments and employee groups shall be required.

6.2 Claims Management services shall include:

6.2.1 Special claims review of open claim files at the request of the County.

6.2.2 Regular quarterly review of all indemnity claims with reserves in excess of $50,000 and/or of problem & complex claims as deemed appropriate by the County.

6.2.3 Ensure that all required payments are made timely and that medical bills are paid within twenty (20) days or objection timely filed.

6.2.4 Indexing of all new claims and periodic reindexing of existing claims.

6.2.5 Quarterly department file reviews will be coordinated and attended by claims administration staff.

6.2.6 Semi-annual defense attorney file reviews will be coordinated and attended by claims administration staff.

6.3 Forms: Forms necessary for the County's processing and benefits or claims information are to be provided at the expense of the adjusting firm to include pre-printed and/or electronic DWC-1 forms, state mandated posting notices, workers' compensation facts brochures, MPN website, MPN brochures and MPN employee notification letters as necessary.

6.4 Managed Care: Managed Care services include medical bill review, utilization review, and nurse case management. The County may award these services separately from the awarded Third Party Administrator, or may award a single contract for all services to one (1) firm, which ever is determined to be in the County's best interest. The firms awarded Managed Care and Claims Administration shall cooperate fully with each other.

6.5 Bill Review Services: The Contractor shall perform bill review, which may include pharmacy review, and provide reports for such reviews to the TPA and the County. The selected Bill Review vendor will provide weekly and monthly reports.

6.6 Utilization Review Services: The Contractor shall be responsible for evaluating situations that may require and/or benefit from referral to the approved UR vendor. It is expected that the experienced examiner will make most first line UR decisions and defer to formal UR assessment when an appropriate medical expertise is needed or when required by the State. The Contractor shall employ utilization standards and guidelines to review treatment requests and outline all review fees to include physician reviews and any automatic per file referral fees. The Contractor's medical director shall be Board certified as required by law. The Contractor shall provide monthly reports.

6.7 Nurse Case Management: The use of Nurse Case Managers shall be pre-approved by the County. The assigned nurse case manager shall be a licensed RN and must have direct experience working with medical providers in Stanislaus County.

6.8 Medical Provider Network (MPN): The County has an established MPN in place and wishes to continue to utilize the existing MPN. The Contractor will be expected to either administer the current MPN while working to improve it or to develop, establish and attain State approval of a new custom MPN that meets all the needs of the County. There must be a specific contact designated who will act as the representative responsible for administering the Medical Provider Network. The administrator will provide any necessary notice to the State, medical providers, claimants and/or their representatives. The County will have final approval of the physicians to be included in the MPN.

7. FINANCIAL ACCOUNTING

7.1 A zero balance account (ZBA) shall be maintained for the purpose of paying benefits that may be due on the claims. The ZBA is a County owned bank account that allows the Consultant to issue and sign checks for claims processed and paid on behalf of the County's Workers' Compensation Program. The ZBA does not maintain a balance and, instead, performs overnight fund transfers in the amount of checks presented to the bank for payment each day.

7.1.1 Payments from the zero balance account will be those sums that should reasonably be paid on benefits mandated and/or required by the California Labor Code on those injuries where such benefits may be due.

7.2 Consultant will reconcile bank statement monthly and will submit copies to the County's Risk Management Division for final verification.

7.3 Consultant shall provide monthly checks/vouchers register of all transactions made for the period. It shall list the checks/vouchers in numerical order, claim number, amount, payee, recoveries of all types and any other information considered necessary.

7.4 At the sole discretion of the County, there may be an annual/yearly financial audit of the zero balance account to ensure the integrity of the account. This account may also be subject to a Grand Jury audit at any time.

7.5 All payments in excess of $5,000 must be approved by the County prior to the check being disbursed.

7.6 The Consultant shall employ measures to mitigate penalties and overpayments and ensure that the County does not incur expenses due to no fault of the County. Penalties that are incurred due to no-fault of the County and overpayments shall be reimbursed to the County no later than the last business day of the month following payment. For example, if a penalty is paid anytime during the month of January, reimbursement is due on or before February 28th. Penalties and overpayments will be documented by monthly reports provided to the County by the Consultant.

7.6.1 For temporary disability overpayments, Consultant will seek credit against permanent disability benefits owed.

7.6.2 For permanent disability overpayments, the Consultant will seek either credit against permanent disability which may be owed in the future or in the event of a compromise and release settlement the Consultant will seek credit for all permanent disability paid including overpayments.

7.7 The Consultant's employees designated as signors on the County's zero balance account must be pre-approved. Prior to obtaining signing authority, the Consultant shall conduct a background investigation including but not limited to an individual credit check.

8. RECORDS, FILES, TRANSCRIPTS, TAPES, ETC.

All records, files, transcripts, computer tapes and any other materials on workers' compensation adjusting activities developed on the County of Stanislaus workers' compensation claims are the property of the County and must be relinquished in good order and condition upon termination of the contract with the adjusting firm without an additional cost.

9. DATA CONVERSION

All open and closed claims must be converted from current claims system to claims administrator's claims system. Conversion must be completed within two months of award.

10. IMPLEMENTATION TIME LINE

The Contractor must provide an implementation time line to illustrate how claims transition, data conversion, etc. will take place.

11. SUPPLEMENTAL SCOPE OF SERVICES

11.1 Audits

11.1.1 In the event of the State audit by OBAE (Office of Benefits Assistance and Enforcement), the Administrator selected shall be responsible for all associated legal costs, including those of the County.

11.1.2 The Administrator is required to cooperate with an independent outside auditor selected by the County. The County reserves the right to audit the administrator at any time and as frequently as the County may deem necessary.

11.2. Penalty assessments and payments

11.2.1 The parties hereto acknowledged that they are familiar with the various penalties that the California Workers Compensation Reform Act of 1989 (and subsequent laws) can impose on both employers and claim administrators. Penalties arising from a failure of the County to provide timely notice of claims or such other employer obligations shall be and remain the sole responsibility of the County and the County hereby agrees to indemnify, defend and hold the Administrator harmless from all claims arising from the imposition of such penalties. Administrative penalties arising solely from the failure of Administrator to comply in a timely and proper manner with its duties as a claims administrator shall be and remain the sole responsibility of the Administrator and the Administrator hereby agrees to indemnify, defend and hold the County harmless from all claims arising from the imposition of such administrative penalties.

11.2.2 More specifically, the parties acknowledge that the California Workers' Compensation Reform Act of 1989 requires first payment of Temporary Disability Indemnity within fourteen (14) days of the County's knowledge of the injury and generally imposes an automatic penalty of 10% of the amount delayed for late indemnity payments, which shall be payable directly to the injured employee without application. Furthermore, the parties agree that unless the Administrator is provided with notice of the claim within ten (10) days of the County's knowledge date of the injury, the above referenced automatic penalty of 10% shall be and remain the sole responsibility of the County.
The Administrator will agree, however, to make good faith effort with due diligence to issue the first Temporary disability indemnity payment within the fourteen (14) day requirement, even in the event that the notice of claim is not received by the Administrator within ten (10) days of the County's knowledge of injury.

11.3 Meetings with the County: The County requires the Contractor to schedule, organize and conduct meetings with County representatives at least twelve (12) times per year. County representatives may include large departments' top management and/or outside defense counsel. The purpose of the meetings will be to review current cases; review the functioning of the workers' compensation program; develop coordinated plans for handling claims; coordinate plans for returning employees to work; settlement authority conferences; departmental claim reviews, and develop and implement appropriate rehabilitation plans. From time to time, the County may request Contractor to address specific issues as may arise during the course of the contract about which County desires additional information.

11.4 Cost Savings: Contractor shall maximize cost savings by efficient and timely provision of benefits to injured workers', utilization review, medical provider networks, recovery of subrogation rights, co-defendant contributions, advantageous negotiated settlements, and early return to work as appropriate.

11.5. Training County Personnel: Contractor shall assist in the training of County staff as required. Design forms, procedures and techniques to improve the claim process. Contractor shall instruct County personnel as directed by the County's Risk Management Division about automated systems and reports. Contractor shall update County staff on current changes in workers' compensation law and case decisions.

11.6 Procedure Manual
Contractor shall assist in preparing and maintaining standards and procedure manual in compliance with state law and County needs with particular attention to a coordination of benefits between the Labor Code and the Government Code.

11.7 Accreditation of Administrator
Contractor shall maintain appropriate accreditation and/or license with five (5) years experience as a provider of workers' compensation services in the State of California (NOTE: include a copy of the license with the RFP submission). Contractor must notify County immediately if accreditation is lost. The Contractor must have provided claims administration for public sector clients.

11.8 Toll Free Telephone Number: The County requests Contractor maintain a toll-free number for access to contractor's office by injured workers and other interested parties. The Contractor shall bear the cost of the toll-free telephone service.

11.9 Claims Examiner Education: All of Contractor's claims examiners assigned to provide service to the County of Stanislaus account will have a solid working knowledge of the Labor Code, including reforms as provided in SB 227, SB 228, SB 899, and any other workers compensation reform currently or hereafter in effect.

11.10 Claims Staff: Contractor shall conduct background checks on all personnel assigned to work on the County's account.

12. SYNOPSIS OF MAJOR SERVICES

The following is a synopsis of the major services requested of the proposer awarded the Claims Management Agreement:

12.1. Initial Services:

12.1.1 Preparation of the basic claims management agreement.

12.1.2 Written Utilization Review procedure to be filed with the State.

12.1.3 Development of the claims payment procedure (subject to County approval).

12.1.4 Design and printing of employer reports, medical referrals, notice to injured employees and any other forms necessary or required.

12.1.5 Establish banking arrangements and/or claims replenishment/reimbursement procedures.

12.1.6 Assume claims management of open files for prior policy years.

12.1.7 Establish all database-coding requirements.

12.2 Ongoing Services:

12.2.1 Issue payments of temporary disability synchronized with the County bi-weekly payroll period.

12.2.2 Issue 4850 payments with vouchers synchronized with the County bi-weekly payroll period.

12.2.3 Review and process all industrial cases in accordance with the requirements of the Department of Industrial Relations and the Workers' Compensation Appeals Board.

12.2.4 Maintain an electronic claim record or file on each reported industrial injury.

12.2.5 Maintain, administer and monitor use of County's Medical Provider Network.

12.2.6 Assure medical treatment is in accordance with agreed upon Utilization Review policy and procedure and is based on readily accepted scientific medicine.

12.2.7 Bill Review reducing fees to RVS or PPO contracts as appropriate.

12.2.8 Maintain on a case-by-case basis current estimates of future claims cost.

12.2.9 Prepare all necessary reports to the various state agencies (annual report to self-insurance plans, OSHA and others as required by law).

12.2.10 Coordination of claims activities required due to legal, investigation or subrogation concerns.

12.2.11 Advise the County on each subrogation/excess insurance reimbursable/recovery case and provide recommendations. Recovery checks on excess cases to be sent to County for deposit at the end of each quarter.

12.2.12 Provide monthly, quarterly, and annual loss reports as needed and or as deemed appropriate by the County's Risk Management Division.

12.2.13 Assist the County's Risk Management Division in returning injured employees to work as soon as medically possible.

12.2.14 Work with County's Disability Management Unit on all problematic claims including, but not limited to:

12.2.14.1 Modified Duty Assignments beyond 30 (thirty) days. Evaluate every thirty (30) days for signs of improvement.

12.2.14.2 Total Temporary Disability in excess of 30 (thirty) days. Evaluate every thirty (30) days, develop and monitor action plans.

12.2.14.3 All claims where hospitalization is necessary.

12.3 The CSAC-Excess Insurance Authority Addendum "A" (attached) Worker's Compensation Claims Administration Guidelines are to be used in addition to the requirements set forth in this Request for Proposal.

EXHIBIT D

Adopted:	December 6, 1985
Amended:	March 4, 1988
Amended:	October 7, 1988
Amended:	October 6, 1995
Amended:	October 1, 1999
Amended:	June 6, 2003
Amended:	March 2, 2007
Amended:	July 1, 2009
Amended:	July 1, 2011
Amended:	March 2, 2012
Amended:	October 4, 2013

ADDENDUM A

WORKERS' COMPENSATION
CLAIMS ADMINISTRATION GUIDELINES

The following Guidelines have been adopted by the CSAC Excess Insurance Authority (hereinafter The Authority or the EIA) in accordance with Article 18(b) of the CSAC Excess Insurance Authority Joint Powers Agreement. It is the intent of these Guidelines to ensure compliance with all applicable Labor Code and California Code of Regulations Sections. In the event that there exists a conflict between the Guidelines, the Labor Code or the Code of Regulations, the most stringent requirement shall apply.

I. CLAIM HANDLING - ADMINISTRATIVE

A. Case Load

1. Each claims examiner assigned to the Member should handle a targeted caseload of 150 but not to exceed 165 claims. In situations where caseloads include future medical and medical only claims, these claims shall be counted as 2:1 in the caseload limit.

2. Supervisory personnel should not handle a caseload, although they may handle specific issues.

B. Case Review and Documentation

1. Documentation should reflect any significant developments in the file and include a plan of action. Plan of action statements should be updated at the time of examiner diary review.

2. The examiner should review the file at intervals not to exceed 45 calendar days.

3. Future medical files should be reviewed at intervalsnot to exceed 90 calendar days. An accomplishment level of 95% shall be considered acceptable.

4. The supervisor shall monitor activity on indemnity files at intervals not to exceed 120 calendar days. Future medical files shall be reviewed by the supervisor at intervals not to exceed 180 calendar days. An accomplishment level of 95% shall be considered acceptable.

5. File contents shall comply with Code of Regulations Sections 10101, 10101.1 and 15400, and be kept in a neat and orderly fashion. If claims are maintained in a paperless system, documents shall be clearly identified (e.g., medical report, WCAB Orders, legal, etc.). An accomplishment level of 95% shall be considered acceptable.

6. All medical-only cases shall be reviewed for potential closure or transfer to an indemnity examiner within 90 calendar days following claim file creation. An accomplishment level of 95% shall be considered acceptable.

C. Communication

1. Telephone Inquiries

Return calls shall be made within 1 working day of the original telephone inquiry. All documentation shall reflect these efforts. An accomplishment level of 95% shall be considered acceptable.

2. Incoming Correspondence

All correspondence received shall be clearly stamped with the date of receipt. An accomplishment level of 95% shall be considered acceptable.

3. Return Correspondence

All correspondence requiring a written response shall have such response completed and transmitted within 5 working days of receipt. An accomplishment level of 95% shall be considered acceptable.

4. Ongoing Claimant Contact

On cases involving unrepresented injured workers who are off work, telephone contact shall be made at a minimum of once every

45 days and within 3 working days after a scheduled surgical procedure. This is in addition to nurse case management involvement on claims where nurse case managers are assigned. An accomplishment level of 95% shall be considered acceptable.

D. Fiscal Handling

1. Fiscal handling for indemnity benefits on active cases shall be balanced with appropriate file documentation on a semi-annual basis to verify that statutory benefits are paid appropriately. Balancing is defined as, "an accounting of the periods and amounts due in comparison with what was actually paid". An accomplishment level of 95% shall be considered acceptable.

2. In cases of multiple losses with the same person, payments shall be made on the appropriate claim file. An accomplishment of 95% shall be considered acceptable.

E. Medicare Reporting

Proper verification of a claimant's status as to Medicare eligibility shall be completed and documented in the claim file. In those cases where the claimant does meet the eligibility requirements, mandatory reporting to the Center for Medicaid Services (CMS) must be completed directly or through a reporting agent in compliance with Section 111of the Medicare Medicaid and SCHIP Extension Act of 2007 ("MMSEA"). An accomplishment of 100% shall be considered acceptable.

II. CLAIM CREATION

A. Three Point Contact

Three point contact shall be conducted with the non-represented injured worker, employer representative and treating physician within 3 working days of receipt of the claim by the third party administrator or self-administered entity. If a nurse case manager is assigned to the claim, initial physician contact may be conducted by either the claims examiner or the nurse case manager. This initial contact should be substantive and clearly documented in the claim file. In the event a party is non-responsive, there should be evidence of at least three documented attempts to reach the individual.

Medical-only claims shall have this three point contact requirement as well. An accomplishment level of 95% shall be considered acceptable.

B. Compensability

1. The initial compensability determination (accept claim, deny claim or delay acceptance pending the results of additional investigation) and the reasons for such a determination shall be made and documented in the file within 14 calendar days of the filing of the claim with the employer. In the event the claim is not received by the third party administrator or self-administered entity within 14 calendar days of the filing of the claim with the employer, the third party administrator or self-administered entity shall make the initial compensability determination within 7 calendar days of receipt of the claim. An accomplishment level of 100% shall be considered acceptable.

2. Delay of benefit letters shall be mailed in compliance with the Division of Workers' Compensation (DWC) guidelines. In the event the employer does not provide notice of lost time to the third party administrator or self-administered entity timely to comply with DWC guidelines, the third party administrator or self-administered entity shall mail the benefit letters within 7 calendar days of notification. An accomplishment level of 100% shall be considered acceptable.

3. The final compensability determination shall be made by the claims examiner or supervisor within 90 calendar days of employer receipt of the claim form. An accomplishment level of 100% shall be considered acceptable.

C. AOE/COE Investigation

If a decision is made to delay benefits on a claim, an AOE/COE investigation shall be initiated within 3 working days of the decision to delay. This may include, but is not limited to, assigning out for witness/injured worker statements, initiating the QME/AME process, requesting medical records, etc. An accomplishment level of 95% shall be considered acceptable.

D. Reserves

1. Using the information available at claim file set up, an initial reserve shall be established for the most probable case value. An accomplishment level of 95% shall be considered acceptable.

2. The initial reserve shall be electronically posted to the claim within 14 calendar days of receipt of the claim. An accomplishment level of 95% shall be considered acceptable.

E. Indexing

All claims shall be reported to the Index Bureau at time of initial set up and re-indexed on an as needed basis thereafter. An accomplishment level of 95% shall be considered acceptable.

The EIA maintains membership with the Index Bureau that members can access.

III. CLAIM HANDLING – TECHNICAL

A. Payments

1. Initial Temporary and Permanent Disability Indemnity Payment

a. The initial indemnity payment shall be issued to the injured worker within 14 calendar days of knowledge of the injury and disability. In the event the third party administrator or self-administered entity is not notified of the injury and disability within 14 calendar days of the employer's knowledge, the third party administrator or self-administered entity shall make payment within 7 calendar days of notification. Initial permanent disability payments shall be issued within 14 calendar days after the date of last payment of temporary disability. Effective 1/1/2013, permanent disability payments shall be issued upon approval of an Award pursuant to Labor Code Section 4650(b)(2). Prior to a PD Award, advances may be due if the employer has not offered the employee a position paying at least 85% of their wages and compensation at time of injury or the employee is not employed in a position paying at least 100% of their wages and compensation at time of injury. This shall not apply with salary continuation. An accomplishment level of 100% shall be considered acceptable.

b. The properly completed DWC Benefit Notice shall be mailed to the employee within 14 calendar days of the first day of disability. In the event the third party administrator or self-administered entity is not notified of the first day of disability until after 14 calendar days, the DWC Benefit Notice shall be mailed within 7 calendar days of notification.

c. An accomplishment level of 100% shall be considered acceptable.

d. Self-imposed penalty shall be paid on late payments in accordance with Section III. A.7 of this document. An accomplishment level of 100% shall be considered acceptable.

e. Overpayments shall be identified and reimbursed timely where appropriate. The third party administrator or self-administered entity shall request reimbursement of overpaid funds from the party that received the funds. If necessary, a credit shall be sought as part of any resolution of the claim. An accomplishment level of 95% shall be considered acceptable.

2. Subsequent Temporary and Permanent Disability Payments

a. Eligibility for indemnity payments subsequent to the first payment shall be verified, except for established long-term disability. An accomplishment level of 100% shall be considered acceptable.

b. Self-imposed penalty shall be paid on late payments in accordance with Section III. A.7 of this document. An accomplishment level of 100% shall be considered acceptable.

3. Final Temporary and Permanent Disability Payments

a. All final indemnity payments shall be issued timely and the appropriate DWC benefit notices sent. An accomplishment level of 100% shall be considered acceptable.

b. Self-imposed penalty shall be paid on late payments in accordance with Section III. A.7. of this document. An accomplishment level of 100% shall be considered acceptable.

4. Award Payments

a. Payments on undisputed Awards, Commutations, or Compromise and Releases shall be issued within 10 calendar days following receipt of the appropriate document An accomplishment level of 95% shall be considered acceptable.

b. For all claims in the primary workers' compensation program (PWC) and/or excess reportable claims, copies of all Awards shall be provided to the Authority at time of payment. An accomplishment level of 95% shall be considered acceptable.

5. Medical Payments

a. Medical treatment billings (physician, pharmacy, hospital, physiotherapist, etc.) shall be reviewed for correctness, approved for payment and paid within 60 days of receipt. An accomplishment level of 100% shall be considered acceptable.

b. The medical provider must be notified in writing within 30 days of receipt of an itemized bill if a medical bill is contested, denied or incomplete. An accomplishment level of 100% shall be considered acceptable.

c. A bill review process should be utilized whenever possible. There should be participation in a PPO and/or MPN whenever possible.

6. Injured Worker Reimbursement Expense

a. Reimbursements to injured workers shall be issued within 15 working days of the receipt of the claim for reimbursement. An accomplishment level of 95% shall be considered acceptable.

b. Advance travel expense payments shall be issued to the injured worker 10 working days prior to the anticipated date of travel. An accomplishment level of 95% shall be considered acceptable.

7. Penalties

a. Penalties shall be coded so as to be identified as a penalty payment. An accomplishment level of 95% shall be considered acceptable.

b. If the Member utilizes a third party administrator, the Member shall be advised of the assessment of any penalty for delayed payment and the reason thereof, and the administrator's plans for payment of such penalty, on a monthly basis. An accomplishment level of 95% shall be considered acceptable.

c. If the Member utilizes a third party administrator, the Member, in their contract with the administrator, shall specify who is responsible for specific penalties.

B. Medical Treatment

1. Each Member shall have in place a Utilization Review process as set forth in Labor Code Section 4610. An accomplishment level of 100% shall be considered acceptable.

2. Disputes regarding utilization review determinations shall be resolved using the Independent Medical Review process set forth in Labor Code Section 4610.5 An accomplishment level of 100% shall be considered acceptable.

3. Nurse case managers shall be utilized where appropriate. An accomplishment level of 95% shall be considered acceptable.

4. If enrolled in a Medical Provider Network, the network shall be utilized whenever appropriate.

C. Apportionment

1. Investigation into the existence of apportionment shall be documented. An accomplishment level of 95% shall be considered acceptable.

2. If potential apportionment is identified, all efforts to reduce exposure shall be pursued. An accomplishment level of 95% shall be considered acceptable.

D. Disability Management

1. The third party administrator or self-administered entity shall work proactively to obtain work restrictions and/or a release to full duty on all cases. The TPA or self-administered entity shall notify a designated Member representative immediately upon receipt of temporary work restrictions or a release to full duty, and work closely with the Member to establish a return to work as soon as possible. An accomplishment level of 95% shall be considered acceptable.

2. The third party administrator or self-administered entity shall notify a designated Member representative immediately upon receipt of an employee's permanent work restrictions so that the Member can determine the availability of alternative, modified or regular work. An accomplishment level of 95% shall be considered acceptable.

3. If there is no response within 20 calendar days, the third party administrator or self-administered entity shall follow up with the designated Member representative. An accomplishment level of 95% shall be considered acceptable.

4. Members shall have in place a process for complying with laws preventing disability discrimination, including Government Code Section 12926.1 which requires an interactive process with the injured worker when addressing a return to work particularly with permanent work restrictions.

5. Third party administrators or self-administered claims professional shall cooperate with members to the fullest extent, in providing medical and other information the member deems necessary for the member to meet its obligations under federal and state disability laws.

E. Supplemental Job Displacement Benefits

1. Supplemental Job Displacement Benefits – Dates of injury on or after 1/1/04 and before 1/1/13: Benefits pursuant to Labor Code Section 4658.5 shall be timely provided. Dates of injury on or after 1/1/13: Benefits pursuant to Labor Code 4658.7 shall be timely provided. An accomplishment level of 100% shall be considered acceptable.

2. The third party administrator or self-administered entity shall secure the prompt conclusion of vocational rehabilitation/SJDB.. An accomplishment level of 95% shall be considered acceptable

F. Reserving

1. Reserves shall be reviewed at regular diary and at time of any significant event, e.g., surgery, P&S/MMI, return to work, etc., and adjusted accordingly. This review shall be documented in the file regardless of whether a reserve change was made. A reserve worksheet shall be utilized and/or detailed rationale substantiating reserve levels shall be documented within the claim file. Where the SIP model does not apply, claims should be reserved for the most probable value. An accomplishment level of 100% shall be considered acceptable.

2. Indemnity reserves shall reflect actual temporary disability indemnity exposure with 4850 differential listed separately. An accomplishment level of 95% shall be considered acceptable.

3. Permanent disability indemnity exposure shall include life pension reserve if

appropriate. An accomplishment level of 100% shall be considered acceptable.

4. Future medical claims shall be reserved in compliance with SIP regulation 15300 allowing adjustment for reductions in the approved medical fee schedule, undisputed utilization review, medically documented non-recurring treatment costs and medically documented reductions in life expectancy. Detailed rationale and/or reserve worksheet shall be documented within the claim file. An accomplishment level of 100% shall be considered acceptable.

5. Allocated expense reserves shall include medical cost containment, legal, investigation, copy service and other related fees. An accomplishment level of 100% shall be considered acceptable.

G. Resolution of Claim

1. Within 10 working days of receiving medical information indicating that a claim can be finalized, the claims examiner shall begin appropriate action to finalize the claim. An accomplishment level of 95% shall be considered acceptable.

2. Settlement value shall be documented appropriately utilizing all relevant information. An accomplishment level of 95% shall be considered acceptable.

3. Where settlement includes resolution of future medical for a medicare beneficiary or an expected medicare beneficiary,the settlement must document the strategy to protect medicare's secondary payor status. An accomplishment level of 95% shall be considered acceptable.

4. Pursuant to CCR15400.2, claim files with awards for future benefits may be administratively closed two years after the last provision of benefits.

H. Settlement Authority

1. No agreement shall be authorized involving liability, or potential liability, of the Authority without the advance written consent of the Authority. The member shall be notified of any settlement request submitted to the EIA. An accomplishment level of 95% shall be considered acceptable.

2. The third party administrator shall obtain the Member's authorization on all settlements or stipulations in excess of the settlement authority provided in

any provision of the individual contract between the Member and the claims administrator. An accomplishment level of 95% shall be considered acceptable.

3. Proof of settlement authorization(s) shall be maintained in the claim file. An accomplishment level of 95% shall be considered acceptable.

IV. LITIGATED CASES

The third party administrator or self-administered entity shall establish written guidelines for the handling of litigated cases. The guidelines should, at a minimum, include the points below, which may be adopted and incorporated by reference as "the guidelines".

1. The third party administrator or self-administered entity shall promptly initiate investigation of issues identified as material to potential litigation. The Member shall be alerted to the need for in- house investigation, or the need for a contract investigator who is acceptable to the Member. The Member shall be kept informed on the scope and results of investigations. An accomplishment level of 95% shall be considered acceptable.

2. The third party administrator or self-administered entity shall, in consultation with the Member, assign defense counsel from a list approved by the Member. Initial referral and ongoing litigation management shall be timely and appropriate. The third party administrator or self-administered entity shall maintain control of the ongoing claim activities. An accomplishment level of 95% shall be considered acceptable.

3. Settlement proposals directed to the Member shall be forwarded by the third party administrator, self-administered entity or defense counsel in a concise and clear written form with a reasoned recommendation. Settlement proposals shall be presented to the Member as directed so as to insure receipt in sufficient time to process the proposal. An accomplishment level of 95% shall be considered acceptable.

4. Knowledgeable Member personnel shall be involved in the preparation for medical examinations and trial, when appropriate or deemed necessary by the Member so that all material evidence and witnesses are utilized to obtain a favorable result for the defense. An accomplishment level of 95% shall be considered acceptable.

5. The third party administrator or self-administered entity shall comply with any reporting requirement of the Member. An accomplishment level of 95% shall be considered acceptable.

V. SUBROGATION

1. In all cases where a third party (other than a Member employee or agent) is responsible for the injury to the employee, attempts to obtain information regarding the identity of the responsible party shall be made within 14 calendar days of recognition of subrogation potential.
   Once identified, the third party shall be contacted within 14 calendar days with notification of the Member's right to subrogation and the recovery of certain claim expenses. If the third party is a governmental entity, a claim shall be filed with the governing board (or State Board of Control as to State entities) within 6 months of the injury or notice of the injury. An accomplishment level of 95% shall be considered acceptable.

2. Periodic contact shall be made with the responsible party and/or insurer to provide notification of the amount of the estimated recovery to which the Member shall be entitled. An accomplishment level of 95% shall be considered acceptable.

3. The file shall be monitored to determine the need to file a complaint in civil court in order to preserve the statute of limitations. An accomplishment level of 95% shall be considered acceptable. If the injured worker brings a civil action against the party responsible for the injury, the claims administrator shall consult with the Member about the value of the subrogation claim and other considerations. Upon Member authorization, subrogation counsel shall be assigned to file a Lien or a Complaint in Intervention in the civil action. An accomplishment level of 95% shall be considered acceptable.

4. Whenever practical, the claims administrator shall aggressively pursue recovery in any subrogation claim. They should attempt to maximize the recovery for benefits paid, and assert a credit against the injured worker's net recovery for future benefit payments. An accomplishment level of 95% shall be considered acceptable.

5. Member (and EIA if applicable) approval is required to waive pursuit of subrogation or agree to a settlement of a third party recovery. This approval shall be documented in the claim file. In cases of self-administered entities, a process should be documented noting the authority levels within the member organization to waive pursuit of subrogation or agree to a settlement of a third party recovery. An accomplishment level of 95% shall be considered

acceptable.

VI. EXCESS COVERAGE

A. Claims meeting the definition of reportable excess workers' compensation claims as defined by the Memorandum of Coverage Conditions Section shall be reported to the Authority within 5 working days of the day on which it is known the criterion is met. Utilize the Excess Workers' Compensation First Report Form available through the EIA website. An accomplishment level of 95% shall be considered acceptable.

B. Subsequent reports shall be transmitted to the Authority on a quarterly basis on all indemnity claims and on a semi-annual basis on all future medical claims or sooner if claim activity warrants, or at such other intervals as requested by the Authority, in accordance with Underwriting and Claims Administration Standards. Utilize the Excess Workers' Compensation Status Report Form available through the EIA website, or a comparable form to be approved by the Authority. An accomplishment level of 95% shall be considered acceptable.

C. Reimbursement requests should be submitted in accordance with the Authority's reporting and reimbursement procedures on a quarterly or semi-annual basis depending on claims payment activity. Utilize the Excess Workers' Compensation Claim Reporting and Reimbursement Procedures available through the EIA website. An accomplishment level of 95% shall be considered acceptable.

D. A closing report with a copy of any settlement documents not previously sent shall be sent to the Authority. An accomplishment level of 95% shall be considered acceptable.

EXHIBIT E

FEE / PRICING PROPOSAL

Proposers must submit pricing using this form, which shall be used as the basis for Phase V of the Evaluation Process. Proposers may submit an alternate pricing proposal separately in addition to this required Pricing Proposal. Such alternate pricing will not be considered as part of the evaluation process but may be incorporated into the final agreement.

The Pricing Proposal format is intended to identify ALL potential fees/costs that may be incurred during the term of the agreement. Additional space has been provided for "Other Charges" to document any potential costs not already identified within the pricing categories provided within the form.

For purposes of developing your claims administration pricing proposal, you should assume 2.5 full-time Claims Examiners and a minimum of 1.5 technical support staff. The County may modify the final staffing profile of the program prior to final contract award, however all proposers must submit their pricing proposal with the same base staff for Claims Examiners and support staff.

It is up to each Individual Proposer to add all other applicable costs into the proposed Claims Administration Flat Fee (management, overhead, supplies, printing, etc.). Your administrative charges must include all other projected costs/fees not already identified on an individual basis within your Pricing Proposal. The County will not pay for any services during the term of any future agreement that are not identified on your pricing proposal submitted during the RFP process, unless otherwise agreed to by the County during the term of the agreement.

For each item, please include the specific dollar or percentage "Rate" (dollar or percentage amount) as well as the "Frequency" of the charge (annual, monthly, weekly, per claim, per bill, etc.). If no fee is contemplated for a specific category, please respond with "No Charge."

Category	Rate	Frequency
Claims Administration		
Claims Administration Annual "Flat" Fee Year One	$ 483,951	Annual
Claims Administration Annual "Flat" Fee Year Two	$ 498,470	Annual
Claims Administration Annual "Flat" Fee Year Three	$ 498,470	Annual
Other Administrative Costs		
Data Conversion $ Pegasus pays 1st $8k. County pays overage ($2-$4ktypical)		
Access to Database/Misc. IT Charges	$ 3 logins included, addit	@ $2k per user per year
Bank Reconciliation	$ No Charge	
Subrogation	$No Charge (legal fees a	re allocated expense)
Indexing *(may be done at no charge through CSAC-EIA)*	$No Charge	
Claim file storage including closed inventory	$ @cost	
Claim file storage including closed inventory	$ No Charge for open Inv	entory
Medicare Reporting	$ No Charge	
Ad hoc report programming per hour	$ No Charge	
Medical Provider Network Administration	$ 2000 Setup Fee (one ti	me)

FEE / PRICING PROPOSAL – CONTINUED

Category	Rate	Frequency
Bill Review		
Fee per Bill to reduce to fee schedule	$ 7.50	Per Bill
% of Savings for PPO Savings below fee schedule	% 18	
% of Savings for Hospital Inpatient	% no additional charge (just PPO rate)	
% of Savings for Hospital Outpatient	% no additional charge (just PPO rate)	
% of savings Negotiated Bill Review	% Considered PPO savings	
Utilization Review		
Nurse Review - per hour	$ 90	Hourly
Doctor Review - per hour	$ 165	Hourly
Peer Review - per hour	$ 250-300*	per review
Pre-Certification (hospital or surgery) - fee per case	$ 95	Hourly
Concurrent Review - fee per case	$ 95/hour	Per Case
Nurse Case Management		
Telephonic Case Management - per hour	$ 75	Hourly
Field Case Management - per hour	$ 95	Hourly
Travel and wait time - per hour	$ 95	Hourly
Mileage charges for travel	$ irs rate	
Catastrophic Case Management	$ 120	Hourly
Other Charges		
f		
Peer Review pricing is subject to complexity and varies based on a variety of factors.		

EXHIBIT F

Stanislaus County
Performance Based Contract Provision - TPA

CSAC Excess Insurance Authority will conduct a biennial claims audit, which will be used as one of the bases for evaluating performance, in addition to providing timely, and accurate claim data as requested.

The claims audit will evaluate compliance with the CSAC EIA Workers' Compensation Claims Administration Guidelines (claim guidelines). The claims audit will measure the percentage of compliance achieved in each of seven (7) selected audit categories.

If the claims audit composite score is below 90%, penalties to the claims administration fees would apply as outlined below.

If the performance as identified by the audit is at a level significantly below the 90% composite score noted previously, such that the County schedules an interim audit with an independent auditor, the cost of said interim audit will be the responsibility of TPA to reimburse the County upon submission of the paid invoice.

Penalty Calculation

TPA can be assessed a penalty of up to $7,000 or $1,000 for each of the audit categories listed below where the composite rating for a category is 90%:

Audit Category

1. Medicare Reporting
2. Three Point Contact
3. Indexing
4. Disability Management
5. Reserving
6. Reimbursement & Recovery
7. Excess Reporting

Auditor Controls

In conducting the annual audit, the auditor will limit the evaluation to areas directly under TPA's control. The audit will be limited to activity performed by TPA since the previous audit. The sample size obtained for each audit category shall be at least forty (40) files representing all County claims, or that audit category will be disregarded. As respects the audit category of "Reserving", the auditor shall consider a file to be in compliance if reserve changes are properly considered and documented and the auditor's reserve recommendation is within 5% of the indicated reserve. However, in the event of a dispute the independent auditor's final opinion will be the determining factor.

Payment of Penalty

The penalty shall apply to claims administration fees earned during the July 1st to June 30th contract year during which the audit is completed. The penalty shall be payable in equal monthly installments over the contract year immediately following the subject audit year. (For example, if the audit is completed during the 2012/13 contract year, the penalty shall be assessed during the 2013/14 contract year.) The penalty is separate from the annual administration fee. Should this contract be cancelled, or not renewed beyond the term of this Agreement, the balance of the penalty shall be payable within thirty (30) days of the termination or non-renewal.

Claim Reports

The monthly, quarterly and annual claim reports are to be fully checked for quality prior to submitting to the County, and will be provided by or before the 15th of the month. Failure to provide accurate and timely reports will result in a $100 penalty for the first report missed. Late or inaccurate reporting penalty will be capped at $2,500 for each contract year, with the penalty being assessed at the end of that contract year. If the County is required to re-request data due to errors identified, or the reports are submitted after the indicated due date and time, the penalty provision will apply.