Adopted: March 5, 1993
Amended: October 4, 1996
Amended: October 6, 2006
Amended: March 6, 2009

MEMORANDUM OF UNDERSTANDING
EXCESS WORKERS' COMPENSATION PROGRAM

This Memorandum of Understanding is entered into by and between Public Risk Innovation, Solutions, and Management (hereinafter referred to as "PRISM") and the participating members who are signatories to this Memorandum.

1. **Joint Powers Agreement.** Except as otherwise provided herein, all terms used herein shall be as defined in Article 1 of the Joint Powers Agreement Creating PRISM (hereinafter referred to as "Agreement"), and all other provisions of the Agreement not in conflict with this Memorandum shall be applicable.

2. **Annual Premium.** The participating members, in accordance with the provisions of Article 14(b)(2) of the Agreement, shall be assessed an annual premium for the purpose of funding the Excess Workers' Compensation Program (hereinafter referred to as the "Program"). Annual premiums shall include expected losses for the policy period, including Incurred But Not Reported losses (IBNR), as well as a margin for contingencies based upon a confidence level as determined by the Board of Directors of PRISM (hereinafter Board), and adjustments, if any, for a surplus or deficit from all program policy periods. In addition, the premium shall include program reinsurance costs and program administrative costs, plus PRISM's general expense allocated to the Program by the Board for the next policy period.

3. **Cost Allocation.** Each participating member's share of annual premium shall be determined pursuant to a cost allocation plan as described in Article 14(b)(2) of the Agreement. The Board approved cost allocation plan is attached hereto as Exhibit A and may be amended from time to time by an affirmative vote of the majority of the Board representing the members participating in the Program.

4. **Dividends and Assessments.** The Program shall be funded in accordance with paragraph 2 above. In general, the annual premium, as determined by the Board, will be established at a level which will provide adequate overall funding without the need for adjustments to past policy period(s) in the form of dividends and assessments. However, should the Program for any reason not be adequately funded, except as otherwise provided herein, pro-rata assessments to the participating members may be utilized to ensure the approved funding level for those policy periods individually or for a block of policy periods, in accordance with the provisions of Article 14(b)(3) of the Agreement.

Pro-rata dividends will be declared as provided herein. Dividends may also be declared as deemed appropriate by the Board.

5. **Closure of Policy Periods.** Notwithstanding any other provision of this Memorandum, the following provisions are applicable:

(a) Upon reaching ten (10) years of maturity after the end of a program period, that period shall be "closed" and there shall be no further dividends declared or assessments made with respect to those program periods except as set forth in paragraph 6(a), below;

(b) Notwithstanding sub-paragraph (a) above, the Board may take action to leave a policy period "open" even though it may otherwise qualify for closure. In addition, the last ten (10) policy periods shall always remain "open" unless the Board takes specific action to declare any of the last ten (10) policy periods closed.

(c) Dividends and assessments (other than as outlined in paragraph 6(a), below) shall be administered to the participating members based upon the proportion of premiums paid to the Program in "open" periods only. For purposes of administering dividends and assessments pursuant to this sub-paragraph, all "open" policy periods shall be considered as one block. New members to the Program shall become eligible for dividends and assessments upon participating in the Program for three (3) consecutive policy periods (not less than 24 months). Participating members who withdraw from the Program prior to the three-year policy period restriction are still eligible for any assessments that arose out of the policy years they participated in the Program.

6. **Declaration of Dividends.** Dividends shall be payable from the Program to a participating member in accordance with its proportionate funding to the Program during all "open" policy periods except as follows:

(a) A dividend shall be declared at the time a program period is closed on all amounts which represent premium surcharge amounts assessed pursuant to Article 14(b)(3) of the Agreement where the funding exceeds the 80% confidence level. This dividend shall be distributed based upon each member's proportionate share of assessment paid and accrued to the policy period being closed.

7. **Memorandum of Coverage.** A Memorandum of Coverage will be issued by PRISM evidencing membership in the Program and setting forth terms and conditions of coverage.

8. **Claims Administration.** Each participating member is required to comply with PRISM's Underwriting and Claims Administration Standards (including Addendum A - W.C. Claims Administration Guidelines) as amended from time-to-time, and which are attached hereto as Exhibit B and incorporated herein.

9. **Late Payments.** Notwithstanding any other provision to the contrary regarding late payment of invoices or cancellation from a Program, at the discretion of the Executive Committee, any member that fails to pay an invoice when due may be given a ten (10) day written notice of cancellation.

10. **Disputes.** Any question or dispute with respect to the rights and obligations of the parties to this Memorandum regarding coverage shall be determined in accordance with the Joint Powers Agreement Article 31, Dispute Resolution.

11. **Amendment.** This Memorandum may be amended by two-thirds of PRISM's Board of Directors and signature on the Memorandum by the member's designated representative who shall have authority to execute this Memorandum. Should a member of the Program fail to execute any amendment to this Memorandum within the time provided by the Board, the member will be deemed to have withdrawn as of the end of the policy period.

12. **Complete Agreement.** Except as otherwise provided herein, this Memorandum constitutes the full and complete agreement of the members.

13. **Severability.** Should any provision of this Memorandum be judicially determined to be void or unenforceable, such determination shall not affect any remaining provision.

14. **Effective Date.** This Memorandum shall become effective on the effective date of coverage for the member and upon approval by the Board of any amendment, whichever is later.

15. **Execution in Counterparts.** This Memorandum may be executed in several counterparts, each of which shall be an original, all of which shall constitute but one and the same instrument.

IN WITNESS WHEREOF, the undersigned have executed this Memorandum as of the date set forth below.

Dated: __3/6/2009_____ _____
Public Risk Innovation, Solutions, and Management

Dated: _____ _____

Member Entity: _____

EXHIBIT A

EXCESS WORKERS' COMPENSATION PROGRAM
COST ALLOCATION PLAN

As delegated by the Board of Directors, the Executive Committee will determine the specific allocation of all costs among the members subject to the following parameters:

Actuarial Analysis

An annual actuarial analysis will be performed using loss data and payroll collected from the members. The analysis will determine the necessary funding rates at various confidence levels and using various discount assumptions. Different rates may be developed for different groups or classes of business as is deemed necessary or appropriate by the Executive Committee. At the March Board meeting, the Board of Directors will select the funding level rates and discount factors to be used based upon the actuarial analysis and recommendations from the Actuary, the Underwriting Committee and the Executive Committee.

Pool Contributions

The total needed deposit pool contribution will be determined by multiplying the rates described above by the payroll for all of the members participating in the pool. Estimated payroll for the year being funded will be used. The Executive Committee may break the pool into different layers for allocation purposes, and may apply a different loss experience modification for each layer as is deemed appropriate based on loss frequency. In general, the lower layers will be subject to greater experience modification and the higher layers will be subject to lower experience modification or no experience modification. Within the layers, the larger members will be subject to greater experience modification than the smaller members. After the experience modification has been applied for each layer, there will be a pro-rata adjustment back to the total needed deposit pool contribution. This amount will be collected from the members at the beginning of the policy period. The actual payroll for the period will be determined after the completion of the policy period and an adjustment to each member's pool contribution will be made to account for the difference between the estimated and actual payroll. Additional contributions will be collected or return contributions will be refunded as appropriate.

Reinsurance Premiums

The reinsurance premium will be determined through negotiations with the reinsurer(s) and approved by the Board upon recommendation of the Underwriting and Executive Committees. This premium will then be allocated among the members based upon their estimated payroll. Adjustments will be

made based on the actual payroll upon completion of the policy period in the same manner as described in the Pool Contribution section above.

PRISM Administration Fees

The total PRISM Administration Fees will be determined through the annual budgeting process with an appropriate amount allocated to the Excess Workers' Compensation Program. These fees will be allocated among the members as determined by the Executive Committee. In general, the basis for this allocation will be each member's percentage of the total pool contributions and reinsurance premium.

Deviation From the Standard

The Executive Committee may establish policies to deviate from the standard allocation methodology selected for each year on a case-by-case basis, if necessary. They may also elect to further delegate some or all of the decision-making authority described herein to the Underwriting Committee.

Adopted: December 6, 1985
Last Amended: July 1, 2019

EXHIBIT B

PUBLIC RISK INNOVATION, SOLUTIONS, AND MANAGEMENT (PRISM) UNDERWRITING AND CLAIMS ADMINISTRATION STANDARDS

I. GENERAL

A. Each Member shall appoint an official or employee of the Member to be responsible for the risk management function and to serve as a liaison between the Member and PRISM for all matters relating to risk management.

B. Each Member shall maintain a loss prevention program and shall consider and act upon all recommendations of PRISM concerning the reduction of unsafe conditions.

II. EXCESS WORKERS' COMPENSATION PROGRAM

A. Members of the Excess Workers' Compensation Program, except those members of the Primary Workers' Compensation Program whose responsibilities are outlined in Section IV below, shall be responsible for the investigation, settlement, defense and appeal of any claim made, suit brought or proceeding instituted against the Member.

1. The Member shall use only qualified personnel to administer its workers' compensation claims. At least one person in the claims office (whether in-house or outside administrator) shall be certified by the State of California as a qualified administrator of self-insured workers' compensation plans.

2. Qualified defense counsel experienced in workers' compensation law and practice shall handle litigated claims. Members are encouraged to utilize attorneys who have the designation "Certified Workers' Compensation Specialist, the State Bar of California, Board of Legal Specialization".

3. The Member shall use PRISM's Workers' Compensation Claims Administration Standards (Addendum A) and shall advise its claims administrator that these standards are utilized in PRISM's workers' compensation claims audits.

B. The Member shall provide PRISM written notice of any potential excess workers' compensation claims in accordance with the requirements of PRISM's Bylaws. Updates on such claims shall be provided pursuant to the reporting provisions of PRISM's Workers'

Compensation Claims Administration Standards (Addendum A) or as requested by PRISM and/or PRISM's excess carrier.

C. A claims administration audit utilizing PRISM's Workers' Compensation Claims Administration Standards (Addendum A) shall be performed once every two (2) years. In addition, an audit will be performed within twelve (12) months of any of the following events:

1. There is an unusual fluctuation in the Member's claim experience or number of large claims, or

2. There is a change of workers' compensation claims administration firms, or

3. The Member is a new member of the Excess Workers' Compensation Program.

The claims audit shall be performed by a firm selected by PRISM unless an exception is approved. Recommendations made in the claims audit shall be addressed by the Member and a written response outlining a program for corrective action shall be provided to PRISM within sixty (60) days of receipt of the audit.

D. Each Member shall maintain records of claims in each category of coverage (i.e. indemnity, medical, expense) or as defined by PRISM and shall provide such records to PRISM as directed by the Board of Directors, Claims Review Committee, Underwriting Committee, or Executive Committee. Such records shall include both open and closed claims, allocated expenses, and shall not be capped by the Member's self-insured retention.

E. The Member shall obtain an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) at least once every three (3) years. Based upon the actuarial recommendations, the Member should maintain reserves and make funding contributions equal to or exceeding the present value of expected losses and a reasonable margin for contingencies.

III. GENERAL LIABILITY PROGRAMS

A. Members of the General Liability 1 or General Liability 2 Programs, except those members of the Deductible Buy-Down Program whose responsibilities are outlined in Section V below, shall be responsible for the investigation, settlement, defense and appeal of any claim made, suit brought or proceeding instituted against the Member.

1. The Member shall use only qualified personnel to administer its liability claims.

2. Qualified defense counsel experienced in tort liability law shall handle litigated claims. Members are encouraged to utilize defense counsel experienced in the subject at issue in the litigation.

3. The Member shall use the Liability Claims Administration Standards (Addendum B) and shall advise its claims administrator that these standards are utilized in PRISM's liability claims audits.

B. The Member shall provide PRISM written notice of any potential excess liability claim in accordance with the requirements of PRISM's Bylaws. Updates on such claims shall be provided pursuant to the reporting provisions of PRISM's Liability Claims Administration Standards (Addendum B) or as requested by PRISM and/or PRISM's excess carrier.

C. A claims administration audit utilizing PRISM's Liability Claims Administration Standards (Addendum B) shall be performed once every two (2) years. In addition, an audit will be performed within twelve (12) months of any of the following events:

1. There is an unusual fluctuation in the Member's claims experience or number of large claims, or

2. There is a change of liability claims administration firms, or

3. The Member is a new member of the General Liability 1 or General Liability 2 Program.

The claims audit shall be performed by a firm selected by PRISM unless an exception is approved. Recommendations made in the claims audit shall be addressed by the Member and a written response outlining a program for corrective action shall be provided to PRISM within sixty (60) days of receipt of the audit.

D. Each Member shall maintain records of claims in each category of coverage (i.e. bodily injury, property damage, expense) or as defined by PRISM and shall provide such records to PRISM as directed by the Board of Directors or applicable committee. Such records shall include open and closed claims, allocated expenses, and shall not be capped by the Member's self-insured retention.

E. The Member shall obtain an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) at least once every three (3) years. Based upon the actuarial recommendations, the Member should maintain reserves and make funding contributions equal to or exceeding the present value of expected losses and a reasonable margin for contingencies.

IV. PRIMARY WORKERS' COMPENSATION PROGRAM

A. Members of the Primary Workers' Compensation Program shall provide the third party administrator written notice of any claim in accordance with the requirements of PRISM. Members must also cooperate with the third party administrator in providing all necessary information in order for claims to be administered appropriately.

B. PRISM shall be responsible for ensuring qualified personnel administer claims in the Primary Workers' Compensation Program and that claims are administered in accordance with PRISM's Workers' Compensation Claims Administration Standards (Addendum A).

C. PRISM shall be responsible for ensuring a claims administration audit utilizing PRISM's Workers' Compensation Claims Administration Standards (Addendum A) is performed once every two (2) years.

D. PRISM shall be responsible for obtaining an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) annually.

V. DEDUCTIBLE BUY-DOWN PROGRAM

A. Members of the Deductible Buy-Down Program shall provide the third party administrator written notice of any claim or incident in accordance with the requirements of PRISM. Members must also cooperate with the third party administrator in providing all necessary information in order for claims to be administered appropriately.

B. PRISM shall be responsible for ensuring qualified personnel administer claims in the Deductible Buy-Down Program and that claims are administered in accordance with PRISM's Liability Claims Administration Standards (Addendum B).

C. PRISM shall be responsible for ensuring a claims administration audit utilizing PRISM's Liability Claims Administration Standards (Addendum B) is performed once every two (2) years.

D. PRISM shall be responsible for obtaining an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) annually.

VI. PROPERTY PROGRAM

A. Members of the Property Program shall maintain appropriate records including a complete list of insured locations and schedule of values pertaining to all real property. Such records shall be provided to PRISM or its brokers as requested by the Executive or Property Committees.

B. Each Member shall perform a real property replacement valuation for all locations over $250,000. Valuations shall be equivalent to the Marshall Swift system and shall be performed at least once every five (5) years for all locations over $1,000,000 and at least once every ten (10) years for all locations with a valuation between $250,000 and $1,000,000. New members shall have an appraisal or valuation performed within one year from entry into the Program.

VII. MEDICAL MALPRACTICE PROGRAM

A. Program I

1. Members of Medical Malpractice Program I (hereinafter Program I) shall be responsible for the investigation, settlement, defense and appeal of any claim made, suit brought or proceeding instituted against the Member.

    a. Members of Program I shall use only qualified personnel to administer its health facility claims.

    b. Qualified defense counsel experienced in health facility law shall handle litigated claims.

    c. Members of Program I shall use the "Claims Reporting and Handling Guidelines" in the PRISM Medical Malpractice Program Operating and Guidelines Manual (hereinafter Operating and Guidelines Manual), and shall advise its claims administrator that these claims handling guidelines are utilized in PRISM's medical malpractice claims audits.

2. Members of Program I shall provide PRISM written notice of any potential excess claim or "major incident" in accordance with the requirements of PRISM and of the excess carrier as stated in the Operating and Guidelines Manual. Updates on such claims or major incidents shall be provided as requested by PRISM.

3. A claims administration audit utilizing PRISM's Claims Reporting and Handling Guidelines in the Operating and Guidelines Manual shall be performed once every three (3) years. In addition, an audit will be performed within twelve (12) months of any of the following events:

    a. There is an unusual fluctuation in the Member's claims experience or number of large claims, or

    b. There is a change of health facility claims administration firms, or

c. The Member is a new member of the Medical Malpractice Program, or

d. The Medical Malpractice Committee requests an audit. The claims audit shall be performed by a firm(s) selected by PRISM. Recommendations made in the claims audit shall be addressed by the Member and a written response outlining a program for corrective action shall be provided to PRISM within sixty (60) days of receipt of the audit.

4. Each Member shall maintain records of claims in each category of coverage (i.e. bodily injury, property damage, expense) or as defined by PRISM and shall provide such records to PRISM as directed by the Board of Directors or applicable committee. Such records shall include open and closed claims, allocated expenses, and shall not be capped by the Member's self-insured retention.

5. Members of Program I shall obtain an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) at least once every three (3) years. Based upon the actuarial recommendations, the Member should maintain reserves and make funding contributions equal to or exceeding the present value of expected losses and a reasonable margin for contingencies.

6. The Member shall have an effective risk management program in accordance with the "Risk Management Guidelines" as stated in the Operating and Guidelines Manual.

B. Program II

1. For Medical Malpractice Program II (hereinafter Program II) Members, PRISM shall be responsible for the investigation, settlement, defense and appeal of any claim made, suit brought or proceeding instituted against the Member. PRISM may contract with a third party administrator for handling of such claims.

2. PRISM shall be responsible for ensuring the third party administrator uses qualified personnel to administer Program II claims.

3. PRISM shall be responsible for ensuring qualified defense counsel experienced in health facility law shall handle litigated claims.

4. PRISM shall be responsible for ensuring a claims administration audit utilizing PRISM's Claims Reporting and Handing Guidelines in the Operating and Guidelines Manual shall be performed once every two (2) years.

The claims audit shall be performed by a firm(s) selected by PRISM. Recommendations made in the claims audit shall be addressed by the third party administrator and a written response outlining a program for corrective action shall be provided to PRISM within sixty (60) days of receipt of the audit.

5. PRISM shall be responsible for obtaining an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) annually.

6. The Member shall have an effective risk management program in accordance with the "Risk Management Guidelines" as stated in the Operating and Guidelines Manual.

VIII. SANCTIONS

A. PRISM shall provide the Member written notification of the Member's failure to meet any of the above-mentioned standards or of other concerns, which affect or could affect PRISM.

B. The Member shall provide a written response outlining a program for corrective action within sixty (60) days of receipt of PRISM's notification.

C. After approval by the Executive or applicable Program Committee of the Member's corrective program, the Member shall implement the approved program within ninety (90) days. The Member may request an additional sixty (60) days from the Executive or applicable Program Committee. Further requests for extensions shall be referred to the Board of Directors.

D. Failure to comply with subsections B or C may result in cancellation of the Member from the affected PRISM Program in accordance with the provisions in the Joint Powers Agreement.

E. Notwithstanding any other provision herein, any Member may be canceled pursuant to the provision of the Joint Powers Agreement.

ADDENDUM TO EXHIBIT B

Adopted: December 6, 1985
Last Amended: July 1, 2019

ADDENDUM A
WORKERS' COMPENSATION
CLAIMS ADMINISTRATION STANDARDS

The following Standards have been adopted by Public Risk Innovation, Solutions, and Management (hereinafter PRISM) in accordance with Article 18(b) of the PRISM Joint Powers Agreement. It is the intent of these Standards to ensure compliance with all applicable Labor Code and California Code of Regulations Sections. In the event that there exists a conflict between the Standards, the Labor Code or the Code of Regulations, the most stringent requirement shall apply.

I. CLAIMS 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 or a small number of conflict claims.

B. Case Review and Documentation

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

2. The examiner shall review indemnity and medical-only files at intervals not to exceed 45 calendar days. Future medical files shall be reviewed at intervals not to exceed 90 calendar days.

3. The supervisor shall review all new claims within 60 calendar days of initial set up and subsequently 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.

4. 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.).

5. Medical Only Claims

   a. If a medical-only claim is still open at 90 calendar days, it shall be transferred to an indemnity examiner.

   b. If, at any time, it is anticipated there will be indemnity benefits paid, the claim shall be transferred to an indemnity claim type.

   c. If the medical-only claim remains open at 180 days, the claim shall be converted to an indemnity claim type, unless there is documentation showing that medical treatment will be ending and the claimant will be discharged from care within the next 30 days, or the claimant is only seeking treatment for a blood-borne pathogen exposure protocol.

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.

2. Incoming Correspondence

   All correspondence received shall be clearly stamped with the date of receipt.

3. Return Correspondence

   All correspondence requiring a written response shall have such response completed and transmitted within 5 working days of receipt.

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 30 days and within 3 working days after discharge from the hospital or outpatient facility following a surgical procedure. This is in addition to nurse case management involvement on claims where nurse case managers are assigned.

D. Fiscal Handling

1. Fiscal handling for indemnity benefits on active cases shall be balanced with appropriate file documentation on a semi-annual basis and prior to sending a benefit termination notice 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”.

2. In cases of multiple losses with the same person, payments shall be made on the appropriate claim file.

E. Medicare Reporting

Mandatory reporting to the Center for Medicaid Services (CMS) shall be completed directly or through a reporting agent in compliance with Section 111 of the Medicare Medicaid and SCHIP Extension Act of 2007 (“MMSEA”). Medicare eligibility shall be documented in the claim file at time of settlement evaluation.

II. CLAIM CREATION

A. Three-Point Contact

Three-point contact shall be conducted on all claims 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 shall be evidence of at least three documented attempts to reach the individual.

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.

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.

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.

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.

D. Reserves

1. Using the information available at claim file set up, an initial reserve shall be established for the most probable case value.

2. The initial reserve shall be electronically posted to the claim within 14 calendar days of receipt of the claim.

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. Blood borne pathogen exposure claims are an exception to this requirement.

PRISM 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.

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. Self-imposed penalty shall be paid on late payments in accordance with Section III. A.7 of this document.

d. 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.

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.

b. Ongoing indemnity payments shall be paid in accordance with Labor Code Section 4650(c).

c. Subsequent DWC benefit notices shall be issued in accordance with CCR 9812.

d. Self-imposed penalty shall be paid on late payments in accordance with Section III. A.7 of this document.

3. Final Temporary and Permanent Disability Payments

a. All final indemnity payments shall be issued timely.

b. The appropriate DWC benefit notices shall be issued in accordance with CCR 9812.

c. Self-imposed penalty shall be paid on late payments in accordance with Section III. A.7. of this document.

4. Award Payments

a. The claim file shall reflect demonstrated efforts to initiate/batch payments on undisputed Awards, Commutations, or Compromise and Release agreements within 10 working days following receipt of the appropriate document, unless the Award indicates payment is due sooner.

b. For all claims in the Primary Workers' Compensation (PWC) Program and/or excess reportable claims, copies of all Awards shall be provided to PRISM at time of payment.

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.

b. The medical provider shall be notified in writing within 30 days of receipt of an itemized bill if a medical bill is contested, denied or incomplete.

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.

b. Advance travel expense payments shall be issued to the injured worker 10 working days prior to the anticipated date of travel.

7. Penalties

a. Penalties shall be coded so as to be identified as a penalty payment.

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.

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.

2. Disputes regarding utilization review determinations shall be resolved using the Independent Medical Review process set forth in Labor Code Section 4610.5.

3. Nurse case managers shall be utilized where appropriate. Rationale for assignment and continued necessity shall be documented in the claim notes at each regular diary review.

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.

2. If potential apportionment is identified, all efforts to reduce exposure shall be pursued.

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.

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.

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.

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.

2. The third party administrator or self-administered entity shall secure the prompt conclusion of SJDB.

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. Where the SIP model does not apply, claims shall be reserved for the most probable value.

2. Indemnity reserves shall reflect actual temporary disability indemnity exposure with 4850 differential listed separately.

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

4. Future medical claims shall be reserved in compliance with CCR 15300 (b)(4) 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.

5. Allocated expense reserves shall include medical cost containment, legal, investigation, copy service and other related fees.

6. A reserve worksheet shall be utilized and/or detailed rationale substantiating reserve levels shall be documented within the claim file.

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.

2. Follow up finalization efforts shall continue and be documented at regular diary reviews until resolution is complete.

3. Settlement value shall be documented appropriately utilizing all relevant information.

4. Where settlement includes resolution of future medical for a Medicare beneficiary or an expected Medicare beneficiary, the settlement shall document the strategy to protect Medicare's secondary payer status.

5. Pursuant to CCR15400.2, claim files with awards for future benefits shall be reviewed for administrative closure two years after the last provision of benefits.

H. Settlement Authority

1. No agreement shall be authorized involving liability, or potential liability, of PRISM without the advance written consent of PRISM. The member shall be notified of any settlement request submitted to PRISM.

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.

3. Proof of settlement authorization(s) shall be maintained in the claim file.

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.

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.

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.

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.

5. The third party administrator or self-administered entity shall comply with any reporting requirement of the Member.

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.

2. 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.

3. 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. If the third party is a non-governmental entity, a complaint shall be filed in civil court within two years in order to preserve the statute of limitations.

4. 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.

5. 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.

6. 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.

7. Member (and PRISM 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 shall 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.

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 PRISM within five working days of the day on which it is known the criterion is met. Utilize the Excess Workers' Compensation First Report Form available through PRISM's website.

B. Subsequent reports shall be transmitted to PRISM 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 PRISM, in accordance with Underwriting and Claims Administration Standards. Utilize the Excess Workers' Compensation Status Report Form

available through PRISM's website, or a comparable form to be approved by PRISM.

C. Reimbursement requests shall be submitted in accordance with PRISM'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 PRISM's website.

D. A closing report with a copy of any settlement documents not previously sent shall be sent to PRISM.

Following is the history of amendments to this document:

Amended: March 4, 1988
Amended: October 7, 1988
Amended: October 6, 1995
Amended: October 1, 1999
Amended: June 6, 2003
Amended: March 2, 2007
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