SCORE
Small Cities Organized Risk Effort
A Joint Powers Authority

SMALL CITIES ORGANIZED RISK EFFORT
SPECIAL EXECUTIVE COMMITTEE
TELECONFERENCE MEETING AGENDA

A Action
I Information

1 Attached
2 Hand Out
3 Separate Cover
4 Verbal

Date/Time: **Friday, May 19, 2023 at 1:00 P.M.**
Location: **TELECONFERENCE**
Call in number: 877-853-5257 (Toll Free)
Conference Code: 916 8441 8336
https://alliantinsurance.zoom.us/j/91684418336?pwd=bDM3dVVNMHZmOXFiZmtrVTVWNWhQQT09

In accordance with the requirements of the Brown Act, notice of this meeting must be posted in publically accessible places, 24 hours in advance of the meeting, in each of the member agencies involved. Documents and material relating to an open session agenda item that are provided to the SCORE Board Members less than 72 hours prior to a regular meeting, will be available for public inspection and copying at 2180 Harvard Street, Suite 460, Sacramento, CA 95815. Per Government Code 54954.2, persons requesting disability related modifications or accommodations, including auxiliary aids or services, in order to participate in the meeting are requested to contact Michelle Minnick at Alliant Insurance at (916) 643-2715 at least 24 hours in advance of the meeting.

This Meeting Agenda shall be posted at the address of the teleconference locations shown below with access for the public via phone/speaker phone.

1. City of Colfax, 33 S. Main Street, Colfax, CA 95917
2. City of Dunsmuir, 5915 Dunsmuir Avenue, Dunsmuir, CA 96025
3. City of Mt. Shasta, 305 North Shasta Boulevard, Mt. Shasta, CA 96067
4. City of Shasta Lake, 4477 Main Street, Shasta Lake, CA 96019

PAGE

A. CALL TO ORDER

B. ROLL CALL

C. APPROVAL OF AGENDA AS POSTED A 1

D. PUBLIC COMMENTS

E. CONSENT CALENDAR A 1

All matters listed under the consent calendar are considered routine with no separate discussion necessary. Any member of the public or Board of Directors may request any item to be considered separately.

Pg. 4 1. Executive Committee Special Meeting Minutes – January 11, 2023 DRAFT

F. JPA BUSINESS

Pg. 7 **1. George Hills Liability Claims Administration Agreement 2023-2028** A 1

The Executive Committee will receive a copy of the proposed agreement and pricing for Liability Third Party Claims Administration.

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2. Intercare Workers' Compensation Claims Administration Agreement A 1
The Executive Committee will receive a copy of the proposed agreement and pricing for Workers' Compensation Third Party Claims Administration.

G. CLOSING COMMENTS

H. ADJOURNMENT

Agenda Item E.

CONSENT CALENDAR

ACTION ITEM

ISSUE: Items on the Consent Calendar should be reviewed by the Board, and if any item requires clarification or amendment, such item should be pulled from the consent calendar for separate discussion. The Board should adopt the Consent Calendar excluding those items removed. *Items requested to be removed from Consent will be placed back on the agenda in an order determined by the President.*

RECOMMENDATION: The Program Administrator recommends adoption of the Consent Calendar after review by the Board of Directors.

FISCAL IMPACT: No financial impact is expected.

BACKGROUND: Items of importance that may not require discussion are included on the Consent Calendar for adoption.

ATTACHMENT:

1. Executive Committee Special Meeting Minutes – January 11, 2023 DRAFT

Small Cities Organized Risk Effort (SCORE)
Special Executive Committee
Teleconference Meeting Minutes
January 11, 2023

Member Cities Present:

Wes Heathcock, City of Colfax
Blake Michaelsen, City of Dunsmuir
Muriel Howarth-Terrell City of Mt. Shasta
Wendy Howard, City of Shasta Lake

Member Cities Absent:

Roger Carroll, Town of Loomis

Consultants & Guests:

Marcus Beverly, Alliant Insurance Services
Michelle Minnick, Alliant Insurance Services

A. CALL TO ORDER

Mr. Wes Heathcock called the meeting to order at 1:33 P.M.

B. ROLL CALL

The above mentioned members were present constituting a quorum.

C. APPROVAL OF AGENDA AS POSTED

A motion was made to approve the Agenda as posted.

MOTION: Wendy Howard SECOND: Blake Michaelsen MOTION CARRIED
Absent: Loomis, Mt. Shasta

D. PUBLIC COMMENT

There were no public comments.

E. CONSENT CALENDAR

1. Executive Committee Special Meeting Minutes - September 30, 2022 DRAFT

A motion was made to approve the Consent Calendar as posted.

MOTION: Blake Michaelsen SECOND: Wendy Howard MOTION CARRIED
Absent: Loomis, Mt. Shasta

F. JPA BUSINESS

F.1. Fort Jones Past Due Balance Status

Marcus Beverly provided the Executive Committee with a status of the Fort Jones past due balance and noted that after a thorough review as well as the credit applied to the banking layer which affected the past due balance amount which is now approximately $300. It was noted that per SCORE Policy & Procedures, there is money from their WC Banking Layer which could be used to offset any past due balance. The Executive Committee has been presented with a copy of the letter and after a discussion it was noted that the letter should be amended to reflect that if they have a claim in the future they will act as a responsible member of the pool and should include a provision that they will be required to fund the banking layer.

A motion was made to amend the letter and send to Fort Jones.

MOTION: Wendy Howard	**SECOND: Muriel Howarth Terrell**	**MOTION CARRIED UNANIMOUSLY**

Absent: Loomis

F.2 SCORE Property Program Refund

Marcus Beverly noted that we had exceeded the cap on our Alliant contract terms as a result of the Property Program increases in recent years – we corrected and a check has been issued and has been shipped to the Treasurer for disbursement to the members in the manner they wish to receive. It was noted that when we switched to the new contract and this will be reviewed annually.

A motion was made to recommend to the Board the allocation presented and may consider to apply fund toward the banking layer or receive a check for the funds.

MOTION: Wendy Howard	**SECOND: Blake Michaelsen**	**MOTION CARRIED UNANIMOUSLY**

Absent: Loomis

F.3. Alliant Program Administration Agreement

The Executive Committee was presented with the Alliant Program Administration Agreement and noted that Alliant attorneys have reviewed the attached and mentioned that the goal is to keep the annual average increase of 3%. Marcus Beverly noted that we will have something more formal as we are working on succession planning as we look toward the future.

A motion was made to recommend approval of the Alliant Agreement.

MOTION: Wendy Howard	**SECOND: Blake Michaelsen**	**MOTION CARRIED UNANIMOUSLY**

Absent: Loomis

G. CLOSING COMMENTS

There were no comments.

H. AJOURNMENT

The meeting was adjourned at 2:02 P.M.

NEXT MEETING DATE: January 27, 2023 Gaia Hotel

Respectfully Submitted,

_____

Muriel Howard Terrell, Secretary

_____

Date

Agenda Item F.1.

GEORGE HILLS GENERAL LIABILITY CLAIMS ADMINISTRATION AGREEMENT 2023-2028

ACTION ITEM

ISSUE: George Hills has provided the attached Agreement for services for three years, with two optional years. Legal counsel has reviewed and provided feedback for the final wording.

The contract includes optional First Party Subrogation Services if members choose to engage George Hills to seek reimbursement for damage to city property. The fee is 30% of the recovery with a minimum of $250.

RECOMMENDATION: Approve the proposed agreement based on Board direction.

FISCAL IMPACT: Annual Fixed Fee Per Year - $90,000 (12 monthly installments of $7,500 each)

*NOTE: 5% increase in Annual Fixed Fee and all hourly rates will be adjusted at the beginning of the first optional year, which would be year six (2028/2029).

One-time Onboarding Fee - $10,000
Annual Administration Fee - $10,000
MMSEA of 2007 annual reporting fee - $500

BACKGROUND: Sedgwick (formally York Risk Services) has provided claims services for SCORE members since inception of the Liability and Workers' Compensation Programs. At the March 31, 2023, meeting the Board provided direction to select George Hills as the Liability claims administrator after a Request for Proposal process was completed in 2023.

ATTACHMENT(S): George Hills Agreement 2023-2028

CLAIMS ADJUSTING AND ADMINISTRATION
SERVICE CONTRACT BETWEEN
THE SMALL CITIES ORGANIZED RISK EFFORT
AND GEORGE HILLS COMPANY, INC.

Contractual Period: July 1, 2023 – June 30, 2028

This Contract is made and entered into by and between the SMALL CITIES ORGANIZED RISK EFFORT, hereinafter referred to as "SCORE," and GEORGE HILLS COMPANY, INC., hereinafter referred to as "GH."

GH is a California Corporation doing business as licensed, independent insurance adjusters and administrators, with John Chaquica, Chief Executive Officer, responsible for contract compliance, terms and corporate governance. Chris Shaffer, Chief Operating Officer, shall oversee the daily operations. The company's corporate office is located at P.O. Box 278, Rancho Cordova, California, 95741, telephone, (916) 859-4800.

SCORE is located at 2180 Harvard Street, Suite 460, Sacramento CA 95815 with Wes Heathcock as the President and Blake Michaelsen as Vice President.

IT IS HEREBY AGREED by and between the parties signing this contract as follows:

1. GENERAL

SCORE is a joint powers authority organized under the laws of California and which possesses the powers common to its Members pursuant to Government Code section 6500, *et seq*. Pursuant to SCORE'S bylaws, SCORE has the power to make and enter contracts in its own name and to do all acts necessary to exercise such common powers for and on behalf of its members**.**

SCORE is desirous of availing itself of liability and property claims adjusting and administration services for those claims assigned per the Scope of Services (Section II). GH is a Third-Party Claims Administrator handling self-insured claims and is ready to and capable of performing such services. As such, GH may act as a representative of SCORE when directed for the investigation, adjustment, processing, and evaluation of general liability, motor vehicle, and potential money damage claims or incidents filed by third parties against SCORE, or against parties for whom SCORE is alleged to be legally responsible, which are premised upon allegations of willful, intentional, negligent, or careless acts and/or omissions ("CLAIMS").

For all other claims, SCORE will report to GH monthly only for purposes of input into the claims system to ensure complete and accurate reports are provided to the excess carrier.

2. SCOPE OF SERVICES

GH agrees to provide complete claim handling services on each accident or incident, as directed by SCORE. Each CLAIM will be subject to the Scope of Services and Client Expressed Authority and Limitations form, attached hereto as Attachment A. SCORE shall determine the scope of services to be provided by GH by signing the Scope of Services and Client Expressed Authority and Limitations for each Contract. The Scope of Services and Client Expressed Authority and Limitations form shall be the controlling document for

the scope of claims adjusting services to be provided by GH for SCORE and may be amended as needed during the Contractual period.

3. DENIAL, COMPROMISE, OR SETTLEMENT OF CLAIMS

It is agreed that SCORE has granted Zero authority to GH for the purpose of compromising, settling, and paying any claims against SCORE being handled by GH. GH will issue payment for legal expenses as defined in Attachment A. Prior approval to compromise or settle any claim or pay any expense will be obtained from the designated claims officer or employee on matters exceeding the authority granted above.

4. FILE RETENTION

GH shall serve as the custodian of the client's data, for documents related to each of the claims subject to this agreement only, and as such shall electronically retain all related records through the life of this contract. Upon termination of this contract, GH shall electronically transfer all of the data pertaining to all claims, either to the SCORE or to a recipient designated by the CLIENT, within 30 days of termination. SCORE and GH may agree via a separate signed agreement to retain records and/or data for a longer period of time, but in the absence of such separate agreement, GH will remove all data received, held, used, or stored in relation to George Hill's performance pursuant to this contract, from its system after 30 days from termination.

5. CONFIDENTIALITY

All data, documents, discussions, or other information developed or received by or for GH in perforamnce of this contract are confidential and not to be disclosed to any person except as authorized by SCORE or SCORE's designee, or as required by law.

6. CONFLICT OF INTEREST

GH covenants that it presently has no interest, direct or indirect, which would conflict in any manner with the performance of services required under this agreement. GH will conduct its business so as to fulfill all legal and ethical requirements, and standards of the industry and state and shall place the best interests of SCORE above any other concerns in the rendering of services. To this end, GH will:

A. Adhere to its ethical obligations to SCORE to deliver honest, competitive, and meaningful service and advice on the services offered.

B. Provide a summary of services and the related terms and conditions for any additional services provided directly by GH or its subsidiaries.

C. In the event GH receives a claim from SCORE in which there arises a "conflict of interest," GH shall immediately notify SCORE of such potential conflict so that SCORE may have the option to choose an independent investigator and/or CLAIMS ADMINISTRATOR.

7. SCORE RESPONSIBILITY

SCORE agrees to the following:

A. SCORE shall cooperate with GH as reasonably necessary for GH to perform its services.

B. SCORE agrees to provide direction to GH as requested regarding particular project requirements.

C. SCORE shall identify a primary contact person(s) for an account as well as for billing and loss run submission. In addition, SCORE shall be responsible for reporting all changes in the primary point of contact to GH.

D. SCORE shall be responsible for reporting to GH all Bodily Injury Claims in addition to all other items noted in Attachment B to this Agreement "Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)."

E. SCORE shall be responsible for updating GH on any changes to coverage/policy language; including limits, retentions/deductibles and coverage changes by June 30 of each year.

F. SCORE shall obtain any necessary consent in the collection of any SCORE data that is transmitted to a third party (i.e., lawyer, actuary, or auditor). SCORE shall provide GH with reasonable assurances that it has the necessary consent to transmit SCORE data to a third party. SCORE acknowledges that the claims data may contain confidential and/or protected health information ("PHI"). In the event SCORE authorizes and directs GH to provide claims data to a third party, SCORE will indemnify, defend and hold harmless GH from and against all claims, damages, losses and expenses, including court costs and reasonable attorneys' fees, arising out of or resulting from:(i) any action against GH that is based on any negligent act or omission of SCORE (ii) the violation of any state or federal statute, ordinance, or regulation by SCORE in transmitting and/or disclosing the claims data.

8. COMPENSATION, FEES AND EXPENSES

The following compensation, fees and expenses, shall be paid in consideration for the services provided by GH as described in this Contract at Section 2 – Scope of Services. This Section shall remain in force and services provided during the entire term of this Contract, unless otherwise amended pursuant to Sections 19 and/or 20 of this Contract.

The compensation to be paid pursuant to this Contract are comprised of three distinct categories:

A: "Administrative Services"

B: "Fees for Claim Adusting Services"

C: "Allocated Costs/Expenses"

The Fees and Costs/Expenses pursuant to subsections "A", "B" and "C" will be billed together monthly in a standard invoice format utilized by GH. Additionally, if the CLIENT elects any optional services identified subsections "F" or "G" below, all additional amounts will also be billed together monthly where applicable.

A. Administration Services

1) One-Time (first year only) On-Boarding Fee: $10,000.00
GH will charge a one-time startup fee which includes, but is not limited to, the planning and coordination of the onboarding process and documentation, detailing specific claims handling instructions, communication protocols, personalize design of claims management information system ("CMIS"), new client setup for bank account, vendors, W-9, etc., and claims triage and assignments. This fee is billed in the first month of service.

2) Annual Administration Fee: $10,000.00 which is billed annually at the beginning of the Contract period and thereafter upon the anniversary of the Contract. This fee is included in the below referenced Annual Fixed Fee but the amount identified here for informational purposes.

3) MMSEA of 2007: There is a $500 annual reporting fee (which is billed annually at the beginning of the Contract period) charged to support the contract with our service provider for reporting to Centers for Medicare Services. This fee is included in the below-referenced Annual Fixed Fee but the amount identified here for informational purposes.

4) System Access Fee: Access to the CMIS is Included in the annual administration fee, it includes the setup and management of up to five (5) user accounts for designated SCORE staff as well as one (1) primary user account and one (1) backup user account per member of SCORE, if requested by the member, all through CXP.

5) iMetrics Report Fee: There will be no charge for our iMetrics business intelligence reports with executive in-person debriefs.

6) George Hills Client Portal: GH operates a client interface which is intended to provide the CLIENT with information regarding claims related and loss information. CLIENT will be provided with access for two (2) users at no additional cost.

7) Custom Reports: Additional charges for custom reporting shall be defined as, requiring a third-party programmer for three hours or more and is client specific.

8) Conversion Fee: GH will pay the Conversion Fee subject to the terms stated below.The Conversion Fee covers costs associated with electronic data conversion, transition, reconciliation of financials, all reports created and vetted, and SCORE sign-off on CMIS set up.

GH extends to new clients the following: GH believes in the establishment of a long-term partnership, and as such shall pay 100% of all costs relating to the data conversion, which is estimated at $20,000. This is based solely on GH being retained under this Contract for five years (whether it is this

Contract or an extension of/amendment to this Contract). If, for any reason the GH is not retained for five years, the CLIENT will be subject to a fee of 20 percent of the full Conversion Fee for each year not retained.

The Conversion Fee does not include, the shipping, storing, scanning, copying, or otherwise handling open or closed paper claims files.

Upon early termination of this Contract, any remaining fee will be added to the penultimate invoice and if not paid, will result in an additional balance due and owed to Contractor

9) Catastrophic Fees: GH recognizes that there are events that are unanticipated and catastrophic. When such events occur, more than the normal number of hours for the handling of such claims are required. As such, to preserve the quality and efficiency of service for which we have been known, GH proposes that should any one catastrophic event occur resulting in eight or more claimants, SCORE and George Hills shall negotiate any additional fees applicable to the specific situation.

10) Annual Fee Escalator: The Annual Fixed Fee and all hourly rates in this Contract shall be adjusted at the beginning of the first optional year, which would be year six (2028/2029), and thereafter for each additional year in which the parties continue under this Contract, by the lesser of, 5% or the change in the Consumer Price Index (CPI-U) for all Urban Consumers for the Western Region using the most recent annual percentage change as of April of the renewal year, but in any event such increase shall not be less than 3%.

11) General File: A general administrative file shall be established and maintained to track effort related to services necessary to fulfill our contractual obligations and not otherwise associated with a claim.

B. Fees for Claims Adjusting Services

The following fees are are calculated on an annual basis but charged to the SCORE monthly (prorated) for services rendered as described herein.

1) Annual Fixed Fee Per Year

In exchange for the services provided under this Contract by GH, SCORE shall pay to GH the following Annual Fixed Fee(s).

Fixed Fee	
Year One – 7/1/2023-6/30/2024	$90,000.00

Due to the dynamic nature of the new claims handling program and obligations of SCORE, including adding members or the loss of member, SCORE and GH agree

to re-evaluate the amount of the Fixed Fee which is to be charged in each of the four (4) subsequent years within the contractual period. In general, a significant change triggering this section would manifest by a 10% change increase or decrease in claim frequency. A significant change could also relate to the alteration of, addition or amendment to scope of services required or requested, even if not specifically arising out of claims filed. If applicable, SCORE and GH will execute an amendment to this Contract stating the agreed upon Fixed Fee applicable to each of the four remaining years.

2) Time and Expense: In the event that SCORE elected to pay for services on a Time and Expenses basis, or where the Catastrophic Fees provision is implemented, the GH Claims team will charge time to each claim using 1/10th of an hour increments for each task performed on a claim. The time spent and further descriptions of each task shall be stated on each monthly invoice. The current hourly rates are:

Litigation Manager:	$200/hour*
Claims Supervisor:	$125/hour*
Claims Adjuster:	$99/hour*
Claims Processing:	$80/hour*

*All hourly rates shall shall increase yearly consistent with the Annual Fee Escalator expressed in Section 8(A)(10), above.

C. Allocated Costs/Expenses

GH will charge to the CLIENT both allocated and non-allocated costs and expenses incurred pursuant to this Contract as stated herein and defined further in Attachment D, "Allocated Expenses."

1) Mileage Reimbursement: Mileage traveled will be paid at the IRS rate in effect at the time the mileage is travled. This section applies to mileage which can be allocated to a specific claim and also mileage which is not allocated to any claim, such as attendance at claim review, board and/or committee meetings requested or required by the CLIENT.

2) Adjuster Travel Expenses**:** GH will separately charge for any travel expenses in connection with attendance at mediations, settlement conferences, trials, etc. This will be subject to prior approval and actual expenses will be submitted with receipts on a monthly basis. This section applies to travel expenses which can be allocated to a specific claim and also travel expenses which are not allocated to any claim, such as attendant at claim review, board and/or committee meetings.

D. Payment Schedule

For year one, SCORE will pay GH the annual fixed fee in twelve equal installments of $7,500 for each of the twelve months in the year. The One-Time On-Boarding Fee and the Annual Administration fee will be added to the first invoice issued by

GH. GH will submit its invoices to SCORE for payment in advance of the month specific on the invoice, and payment shall be made by SCORE, within a reasonable period of time, not to exceed thirty (30) days from the date of the invoice.

E. Electronic Funds Transfer or Direct Deposit

GH has determined that the most efficient and secure default form of payment for goods and/or services provided under Contract with SCORE shall be Electronic Funds Transfer (EFT) or direct deposit unless an alternative method of payment is deemed appropriate by both GH and SCORE and agreed to in writing.

GH will submit a direct deposit authorization request via to SCORE with banking and vendor information, and any other information that the SCORE determines is reasonably necessary to process the payment and comply with all accounting, record keeping, and tax reporting requirements.

At any time during the duration of the Contract, GH may submit a written request for an exemption to this requirement. Such request must be based on specific legal, business or operational needs and GH will explain why the payment method designated by the SCORE is not feasible and an alternative is necessary.

F. First PartySubrogation Services And Fees

GH is a claim administration firm experienced in the handling of first party subrogation claims and is ready and capable of performing such services on behalf of the members of SCORE. The fee for these services is 30% of the gross recovery. SCORE elects to incorporate the Subrogation Services to be utilized by its members, as agreed by members on a case-by-case basis and as described more fully in Attachment A, Scope of Services and Client Expressed Authority and Limitations, Section (I)(A)(J).

G. Optional Services

GH employs “in-house” attorneys which have vast experience in claims and litigation handling, problem resolution, issue identification and investigation, and advice and consultation, for all types of claims and issues which may arise for a public entity. Should the special circumstance arise whereby SCORE requests additional services by a GH attorney, including those identified in the list below, the services will be provided on a time and expenses basis and at the rate of $200.00 per hour, billed using 1/10th of an hour increments for each task performed on a claim or issue. The fees charged for these services will be in addition to any other compensation defined in this

Litigation Management

Monitoring Counsel

Outside General and Special Counsel

Trial/Mediation/Board Meeting Attendance

Legal Training and Seminars

GH can also provide Professional and Financial Services related to risk management and loss prevention in alignment with the scope of services for the same rate referenced above.

NOTE: These services are traditionally Time and Expense, however an annual fee can be considered.

9. TERM AND TERMINATION

The term of this contract shall commence on July 1, 2023 and will remain effective for a period of five (5) years, through and including June 30, 2028. After the initial term, SCORE, at its sole discretion, may exercise one option to extend this Agreement for two years by notifying GH of such extension(s) at least 30 days prior to the anniversary date.

Termination for Convenience: SCORE may at any time and for any reason terminate this Agreement upon one-hundred eighty (180) days written notice to GH pursuant to section 18 of this Contract. Notice shall be deemed served on the date of mailing. Upon receipt of such notice, GH shall discontinue services at the end of the 180-day period in connection with the scope of services of this Agreement. Upon such termination, GH shall be entitled to payment from SCORE for services completed and provided through the date of termination, per Section 8. Upon the mutual agreement of both parties, this Contract may be terminated with less than one-hundred eighty (180) days notice.

Upon completion of data conversion or termination of this Agreement and return of data back to SCORE (electronic and/or hard copy), GH will destroy any remaining files.

10. FAIR EMPLOYMENT

It is the policy of GH to provide fair and equal treatment to all staff members. GH is an Equal Opportunity Employer and does not discriminate in any way against any person on the basis of age, race, sex, color, national origin, national ancestry, physical disability, medical condition, mental disability, religion, creed, marital status, sexual orientation, gender identification, gender expression, use of family care leave or any other classification deemed protected by law.

11. INDEPENDENT CONTRACTOR

In performing claims administrative services herein agreed upon, GH, and all GH employees, shall have the status of an independent contractor of the SCORE and shall not be deemed to be an officer, employee, or agent of SCORE.

12. INDEMNIFICATION

GH shall hold harmless, defend and indemnify SCORE, its officers, officials, employees and volunteers from and against all claims, damages, losses and expenses including attorney fees which actually or allegedly arise out of the performance of the work described herein, caused in whole or in part by any negligent act or omission of GH, its contractor, any subcontractor, anyone directly or indirectly employed by any of them or anyone for whose acts any of them may be liable, except where caused by the sole negligence, or willful misconduct of SCORE, its officers, officials, employees and volunteers.

SCORE shall defend, at no cost to GH, in those cases wherein the alleged liability or damage is not caused by negligent acts, errors or omissions of GH, but GH is named in a

filed or verified complaint simply by virtue of the fact it is the CLAIMS ADMINISTRATOR's firm on a given claim.

13. INSURANCE

GH shall provide SCORE with Certificates of Insurance duly executed by an authorized representative of insurance company or companies authorized to transact business in the State of California, and said Certificates shall evidence that the GH has in full force and effect: (1) $1,000,000 per occurrence Commercial General Liability coverage applying to bodily injury, personal injury, and property damage; (2) $3,000,000 Each Claim/Annual Aggregate Professional Liability coverage; (3) statutory coverage for workers compensation; (4) fidelity coverage for theft of SCORE property in the amount of $1,000,000 per loss; and (5) Cyber/Internet Liability coverage in the amount of $1,000,000. GH shall include SCORE as an additional insured under the Commercial General Liability insurance referenced above by endorsement or policy wording. GH shall include SCORE as loss payee under the fidelity insurance policy.

For any General Liability claims related to this contract, GH's insurance coverage shall be primary insurance coverage on forms reasonably acceptable to the SCORE, its officers, officials, employees, and volunteers. Any insurance or self-insurance maintained by the SCORE, its officers, officials, employees, or volunteers shall be excess of GH's insurance and shall not contribute with it.

GH hereby grants to SCORE a waiver of any right to subrogation which any insurer of GH may acquire against the SCORE by virtue of the payment of any loss under such insurance. GH 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 SCORE has received a waiver of subrogation endorsement from the insurer. However, the Workers' Compensation policy shall be endorsed with a waiver of subrogation in favor of the SCORE for all work performed by the Contractor, its employees, agents and subcontractors.

GH will provide ten (10) days written notice, prior to the cancellation or reduction in insurance coverage and all necessary certificates of insurance will be provided.

14. EMPLOYEE SOLICITATION

During the period of this contract, and for a period of one (1) year thereafter, GH agrees not to solicit for employment any SCORE employee contacted during the performance of this contract; SCORE agrees not to solicit for employment, or employ, during the period of this contract, and for a period of one (1) year thereafter, any employee of GH contacted by the SCORE during the performance of this contract.

15. PERMITS, LICENSES, CERTIFICATES

GH, at GH's sole expense, shall obtain and maintain during the term of this Contract, all permits, licenses, and certificates required in connection with the performance of services under this Contract, including appropriate business license.

16. ARBITRATION

GH and SCORE agree that in the event of any dispute with regard to the provisions of the Contract, the services rendered or the amount of GH's compensation and the dispute cannot be settled through informal negotiation, the parties agree first to try in good faith to settle the dispute by mediation before resorting to arbitration. The parties agree that any and all disputes, claims or controversies arising out of or relating to this Agreement shall be submitted to a mutually agreed upon mediator for mediation, and if the matter is not resolved through mediation, then it shall be submitted to a mutually agreed upon arbitrator for final and binding arbitration. Either party may commence mediation by providing to the selected mediator and the other party a written request for mediation, setting forth the subject of the dispute and the relief requested. The parties will cooperate with one another in selecting a mediator from a panel of neutrals and in scheduling the mediation proceedings. The parties agree that they will participate in the mediation in good faith and that they will share equally in its costs. All offers, promises, conduct and statements, whether oral or written, made in the course of the mediation by any of the parties, their agents, employees, experts and attorneys, and by the mediator are confidential, privileged and inadmissible for any purpose, including impeachment, in any arbitration or other proceeding involving the parties, provided that evidence that is otherwise admissible or discoverable shall not be rendered inadmissible or non-discoverable as a result of its use in the mediation. Either party may initiate arbitration with respect to the matters submitted to mediation by filing a written demand for arbitration at any time following the initial mediation session. The mediation may continue after the commencement of arbitration if the parties so desire. Any arbitration arising out of or related to this Agreement shall be conducted in accordance with the provisions of the California Arbitration Act, CCP section 1280, et seq. In any arbitration arising out of or related to this Agreement, the arbitrator shall award to the prevailing party, if any, the costs and attorneys' fees reasonably incurred by the prevailing party in connection with the arbitration.

17. FORCE MAJEURE CLAUSE.

GH shall be relieved of any liability if unable to meet the terms and conditions of this Agreement due to any "Act of God", natural disasters such as earthquake or fires, floods, riots, epidemics, pandemics, including COVID-19 regulations or restrictions issued by federal, state or local governmental authorities, strikes, or any act or order which is beyond the control of GH, provided GH takes all reasonable steps practical and necessary to effect prompt resumption of its responsibilities hereunder.

18. NOTICES

All notices to GH shall be sent via e-mail (preferred) or by certified U.S. Mail, postage prepaid, to the following address:

GH
George Hills Company, Inc.
Attn: John Chaquica, CEO
P.O. Box 278
Rancho Cordova, CA 95741.
E-mail: John.Chaquica@GeorgeHills.com

All notices to the SCORE shall be personally served or mailed, postage prepaid, to the following address:

Client:
Small Cities Organized Risk Effort
c/o Alliant Insurance Services
Attn: Program Director
2180 Harvard Street, Ste. 460
Sacramento, CA 95815

This section only, regarding Notices, may be amended unilaterally by either party by and through the mailing of new or amended contact information to the other party via certified U.S. Mail at any time.

19. AMENDMENT

GH and SCORE agree that the terms and conditions of the Contract may be reviewed or modified at any time. Any modifications to this Contract, however, shall be effective only when agreed to in writing by both the SCORE and GH, excepting only, modifications to the contact information to which Notices shall be sent under Section 18.

20. AMENDMENT DUE TO GOVERNMENTAL, POLITICAL, OR LEGISLATIVE CHANGES

GH and SCORE agree that governmental, political, or legislative changes may impact the work of GH and SCORE on behalf of SCORE members. GH reserves the right, for the benefit of both parties, to require an amendment to any portion(s) of this Contract, expressly including the compensation, fees, and expenses stated in Section 8, in response to any change to, addition or deletion of any statute, rule, regulation, or policy which materially impacts the liability of public entities in California, damages for which public entities may become responsible, and/or the handling, administration, adjustment, payment, and/or reporting related to services performed under this Contract.

21. NO THIRD PARTY BENEFICIARIES

Although SCORE members are intended to receive services pursuant to this Contract, Members are not and shall not be deemed to be intended third-party beneficiaries and shall have no right to independently enforce any provision of this Contract or to make any demand upon GH independent from SCORE. Notwithstanding this section, any SCORE member may separately agree with GH for first party subrogation services as described in this Contract.

22. ENTIRE CONTRACT

GH and SCORE agree that this contract constitutes the entire contract of the parties regarding the subject matter described herein and supersedes all prior communications, contracts, and promises, either written or oral.

23. TIME OF ESSENCE

Time is of the essence in respect to all provisions of this Contract that specify a time for performance: provided, however that the foregoing shall not be construed to limit or deprive a party of the benefits of any grace or use period allowed in this Contract.

5/8/23

Date

BY: _____

John E. Chaquica, CEO
GEORGE HILLS COMPANY INC.

_____

Date

BY: _____

Wes Heathcock, President
SMALL CITIES ORGANIZED RISK EFFORT

ATTACHMENT A

SCOPE OF SERVICES AND SCORE EXPRESSED AUTHORITY

AND LIMITATIONS UNDER THE CONTRACT

This Attachment A is intended to provide the scope of services and specific service expectations in the Service Contract that would not otherwise require revision during the contract period and which may differ from or elaborate upon our Client Service Profile. Services to be provided by GH on behalf of SCORE may include all or some of the following based on the discretion of the assigned GH adjuster after consideration of the needs presented by each claim or case:

I. SERVICES INCLUDED IN THE CONTRACT

A. General Administrative Services

Throughout each year GH performs numerous functions which support claims administration on behalf of the Client, but do not include any claims handling, and are performed by non-claims personnel. Additionally, in the first year of a new client there are several "on-boarding" services that are general and administrative in nature. Below is a list of such services which are included within the terms of this Contract:

1) Access to CMIS and training.
2) A monthly listing of open claims, showing expense categories, reserves, and total incurred.
3) Monthly claim summary reports.
4) Providing loss run data and required reports.
5) Providing annual reports to outside agencies.
6) Filing of regulatory reports (such as 1099, W-9, etc.).
7) Establish and maintain a trust fund to pay indemnity and expenses that may be due on claims. The amount to be maintained in the trust fund shall be determined by SCORE.
8) If the trust fund is not set-up with the GH preferred bank—California Bank & Trust, there may be an additional set-up fee (other banks processes can be extraordinarily time consuming).
9) New bank account set up (signature cards, test checks, online access, set up bank in CXP).
10) Discussion and agreement on the Approval process.
11) Process checks weekly.
12) Submit positive pay if applicable/monitor positive pay (review daily emails from bank for exceptions).
13) Maintain a copy of all checks drawn by GH to pay claims and claims related expenses.
14) Submit monthly check registers of all transactions made for the period.
15) Monitor account balance, prepare replenishment requests as needed (customize request for each client's need).
16) Monthly bank reconciliation (prepared and sent to SCORE).
17) Special reports that requested to go with billing invoices (by member, claim type, etc.).
18) Payment of invoices that are pass-throughs (i.e., invoices for medical record copies, ExamWorks, etc.).
19) Certificates of insurance as required by the Contract.

B. Investigative Services

1) Receipt and examination of all reports of accidents or incidents that are or may be the subject of claims.
2) Investigate accidents or incidents as warranted, to include on-site investigation, photographs, witness interviews, determination of losses and other such investigative services necessary to determine all SCORE losses but not to include extraordinary investigative services outside the expertise of GH.
3) In the event SCORE or other agency conducts any investigation, and upon Client's request, GH shall review and analyze for liability and/or damage issues and for possible additional follow-up investigation.
4) Maintain service on a 24-hour, 7 days per week basis, to receive reports of any incident or accident which may be the subject of a liability claim and provide immediate investigative services to the extent necessary to provide a complete investigation.
5) Undertake items of investigation requiring special handling for CLIENT at the direction of the CLIENT's Attorney or authorized representative.

C. General Liability and Property Claim Handling Services - Pre-Litigation

1) Promptly set up a claim file upon receipt of the claim and maintain a claim file on each potential or actual claim reported.
2) Assess and evaluate the nature and extent of each claim and establish claims reserves for indemnity and legal expense.
3) GH will follow any SCORE policy regarding tort claim rejection instructions, including rejection and return of an untimely or insufficient claim.
4) Ensure timely tort claim handling, including contact and follow-up with claimants regarding claim issues and processing.
5) Any bodily injury claim that is being pursued shall be indexed. Notice only matters or precautionary bodily injury claims that are not pursued do not need to be indexed.
6) Determine the need for defense representation, recommend legal counsel, and support litigation efforts of defense counsel.
7) Report claims to the excess insurer in compliance with excess carrier's reporting requirements and coordinate with the excess insurer on a claim's progress in accordance with the excess insurer's reporting requirements.
8) Maintain records on any such claim and notify SCORE when SCORE is about to exhaust the Self-Insured Retention.
9) Obtain settlement contracts and releases upon settlement of claims or potential claims not in litigation.
10) Perform periodic reviews, as needed, of SCORE files and claims as well as statutory requirements to ensure compliance including excess insurance related requirements.
11) Perform the necessary data gathering for the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) and the Set Aside Contracts in compliance with Section 111 of the MMSEA including the required reporting. *(See Attachment B)*
12) To the extent there is privileged information or PHI shared between agencies, which is subject to protection under HIPAA, GH shall implement all necessary measures in compliance with the Act and will execute a Business Associates Agreement (BAA).

D. Litigation Management and Support Services

1) Claims Processors, Adjusters, and/or Supervisors will perform the following services in relation to litigated or to-be-litigated claims:
   a. Upon notification by the SCORE that litigation has been filed on an General Liability or Property claim, GH shall follow the litigation referral process as outlined in the Client Expressed Scope of Work Instructions form.
   b. Work cooperatively with SCORE in choosing outside counsel from approved panel, and assist defense counsel in on-going litigation defense efforts.
   c. Obtain regularly updated Litigation Plan and Budget from defense counsel.
   d. Review legal bills for compliance with Litigation Plan and Budget; Review, evaluate and adjust defense counsel invoices for legal services.
   e. Cooperate with and assist defense counsel assigned to litigation of open claims and provide such investigative services as directed during pre-trial and trial stages.
   f. Assist in responding to discovery or preparing discovery.
   g. At the request of the SCORE, attend mediations and settlement conferences on behalf of SCORE.
   h. Appear on behalf of SCORE in small claims actions filed against SCORE on open claims handled by GH.
   i. Read and analyze relevant communications from defense counsel. Regularly discuss, review, and contribute to investigation, discovery, and case strategy with defense counsel.
   j. Cooperate with counsel as a team with an open communication approach on each case to obtain the most economical and best result for the SCORE.

2) If agreed upon and for additional fees, GH will assign one of GH's in-house attorneys to serve as the Litigation Manager for designated claims which fall into any of the categories identified below:
   - Claims or cases designated as "Watchlist" based on agreement of SCORE and GH;
   - All litigated matters involving an alleged violation of civil rights by law enforcement officers or public employees;
   - Matters with an incurred amount of $250,000 or greater;
   - Any matter with fiscal or political significance

The Litigation Management services to be performed may include:

   a. Assess excess coverage reporting requirements and potential issues related to coverage and advise GH personnel of the need for reporting
   b. Identify the need for evidence preservation including scope and duration
   c. Assess need for early intervention by and assignment to defense counsel where appropriate
   d. Assess need for early retention and evaluation by expert witnesses
   e. Review case evaluations, correspondence and status reports forwarded by defense counsel to advise SCORE staff and/or the Board of Directors on proper handling including settlement, trial, or appellate work
   f. Monitor the case and advise on updating reserves and financial information on the file to maintain current and accurate loss information
   g. Provide advice on and/or assign defense counsel and ensure that a plan of action, budget, and evaluation of the case is prepared and maintained by defense counsel on designated cases

h. Obtain, review, and analyze status reports of defense counsel and participate in selection of strategy, need for motions, retention of experts, and trial preparation
i. Advise SCORE on settlement positioning, need for authority, risks of trial, and valuation of case deemed prudent for settlement purposes

E. Reports and Procedures

1) Within thirty (30) days of assignment, or sooner if practicable, required, or requested, GH will provide SCORE with a report pursuant to specified claims handling instructions, showing name(s) of claimant(s), type of claim, date of loss, comments on liability, reserve recommendations, settlement recommendations, and other pertinent information. Subsequent to the initial thirty (30) day report, GH will report as often as warranted by any important change in status but no longer than every ninety (90) days until the claim closes unless extended diary is appropriate.
2) All original reports, documents, and claim data of every kind or description, that are prepared in whole or in part by or for the GH in connection with this contract shall be SCORE's property and constitute the GH's work product for which compensation is paid. A copy of all reports, documents, and claim data of every kind or description that is in whole or in part by or for the SCORE is the property of GH. Additional copies of original reports, documents, and data requested by SCORE will be at SCORE's expense in accordance with this contract.
3) GH agrees that SCORE have access and the right to audit and reproduce any of the GH's relevant records to ensure that the SCORE is receiving all services to which the SCORE is entitled under this Contract or for any purpose relating to the Contract.

F. Data

As required by industry standards, cyrber insurance carriers, and auditors, George Hills maintains a secure environment for the transmission of Customer Data, utilizing encryption consistent with modern industry standard practices such as Federal Information Processing Standards FIPS 140-2 and/or NIST SP800-52 and utilizing industry accepted encryption technologies such as server certificate-based authentication. George Hills acknowledges and agrees that encryption may not be available for every communication through the System, or for all data, however when such encryption is available and applicable, encryption shall be utilized. Pursuant to the terms of this Agreement, GH will:

1) Allow SCORE to utilize GH's claims management system—CXP (ClaimsXpress) for all claims and litigated cases subject to this Agreement.
2) Record all claim information including all financial data.
3) Provide SCORE and broker "Read only" on-line access to the claims data system (up to five users), if desired by SCORE.
4) Provide monthly standard loss runs and check registers, which will be posted to a client portal.
5) Provide annual claims data report upon request. Written authorization and/or a Business Associate Agreement may be required for confidential information protected by HIPAA.
6) Provide assistance to SCORE in developing customized reports when requested (may require additional charge).
7) Arrange for electronic file conversion for any open and closed claims at the direction of SCORE.

G. Claim Review Meetings

GH shall meet with SCORE to review and discuss SCORE's claims inventory and claims results of specified periods and delivery of services by GH on dates mutually acceptable to both SCORE and GH.

1) GH will review all SCORE pooled claims once per year
2) GH will review "Watchlist" claims twice per year

H. Financial Accounting

1) Establish and maintain one trust fund account for use by SCORE, on behalf of its members, for the purpose of paying indemnity and expenses that may be due on the claims. The amount to be maintained in the trust fund shall be determined by the Client.
2) Maintain a copy of all checks drawn by the GH to pay claims and claims related expenses.
3) Submit monthly check registers of all transactions made for the period.
4) Complete or update Attachment B "Preferred Method of Check Processing" for check processing options.
5) Approval process shall be documented in GH Client Expressed Scope of Work Standards and Instruction Form.
6) GH will provide monthly bank reconciliation reports to SCORE for audit purposes.

I. Third Party Subrogation Services

1) GH personnel are well versed in the identification, handling, and pursuit of subrogation claims arising out of CLAIMS which are the subject of this Contract. Included within this contract, GH will perform the following functions:
2) Identify potential opportunities to recover from persons, businesses, and entities other than the SCORE.
3) Prepare and file a claim with each identified entity.
4) As applicable, tender defense to or seek recovery from any identified entity.
5) With the assistance of counsel, prepare and file any necessary litigation required to effect the claim of recovery on behalf of the SCORE
6) Manage litigation related to such claims made to other person, businesses or entities

J. First Party Subrogation Services

GH is a claim administration firm experienced in the handling of first party subrogation claims and is ready and capable of performing such services on behalf of SCORE. GH does not handle subrogation claims with a value of less than $1000. For any claim in excess of $1,000, any SCORE member may utilize the first party subrogation services of GH. To the extent that such services are utilized by any SCORE member, the fee to be paid to GH for such services will be taken from the recovery obtained by GH on behalf of the respective member. Any additional fees associated with this services shall be paid directly by the SCORE member. Nothing in this section, or arising out of the services provided by GH to any SCORE member under this section, is intended to, or shall actually, make any SCORE member an intended third party beneficiary to this Contract since any consideration paid in exchange for said services will be paid solely by the SCORE member which utilizes the services provided by GH under this section.

II. OPTIONAL SERVICES NOT INCLUDED IN THE CONTRACT BUT AVAILABLE TO SCORE

George Hills has law enforcement and legal professionals available to assist established and prospective law enforcement agencies with all aspects of public safety and police protection. They have the training and experience to advise and support entities facing difficult issues, such as:

- Audits of law enforcement policies, procedures, practices, and training to advise as to best practices.This includes review of loss data, risk assessment, and recommendations as to best practices;
- Risk identification and mitigation;
- Employee and personnel issues, including background investigations, Workers' Compensation, and Labor Relations;
- Employee discipline;
- Internal affairs investigations;
- Creation and formation of new police departments;
- Critical incident response and crisis management;
- Public Information response;
- Review and analysis of high profile, high exposure criminal, administrative, and civil claims;
- Training seminars tailored to issues faced by individual agencies.
- Additional services by GH in-house attorneys including monitoring counsel and/or special counsel where a "reprentative capacity" is not required. While GH in-house attorneys may oversee litigation, serving as monitoring counsel requires substantially more work and provides greater oversight including review of all pleadings, discovery, motions, briefs, and independent analysis of the current state of litigation and/or options available. GH attorneys may also be tasked with providing input, guidance, and counsel on matters were would not otherwise be subject to this Agreement.

Their long and distinguished career has included working with law enforcement agencies across California and helping to solve their most difficult problems.

These services can be made available to SCORE at the rate of $225 per hour.

III. SCORE EXPRESSED AUTHORITY AND LIMITATIONS

The list immediately below contains numerous services provided in this Contract for which GH requests the SCORE expressly establish authority and/or limitations, on the ability of GH to act on behalf of the SCORE. The SCORE will check the appropriate box establishing the authority of GH to act or the limitation as to that authority.

INVESTIGATION:

☐ George Hills will conduct all investigations

☐ SCORE will conduct all investigations

☒ SCORE will direct GH on each claim as to who performs investigations

In the event the Client or other agency conducts any investigation, GH shall review for completeness.

Retention of Vendors (appraisers, translators, copy services, Independent Adjuster, IME's, Surveillance, etc.):

☒ Must be preauthorized by SCORE

REJECTION OF CLAIMS:

SCORES position regarding rejections (*e.g., if entity so dictates, a claim will be rejected for insufficiency)*. Check all that apply.

Protocols for Rejections

☐ GH needs authorization

☐ GH does not need authorization

☐ GH sends the Rejection

☒ SCORE sends the Rejection

☐ GH sends out Denial Letter simultaneously with Rejection outlining the reason

LITIGATION:

Check all that apply.

☒ GH will handle litigated claims

- ☒ Full
- ☐ As assigned
- ☐ Check Issuance and Data Input
- ☐ Data Input only

☐ SCORE will handle litigated claims inhouse, with GH to capture data into SIMS

- ☐ SCORE will send data to GH weekly
- ☐ SCORE will send data to GH monthly

Mandatory Settlement Conferences

☐ GH always attends

☒ At SCORE request only

Small Claims Actions filed against SCORE

☐ GH always appears

☒ At SCORE request only

Legal Counsel

☒ GH must have SCORE authorization to refer to outside Legal Counsel

☒ GH must use SCORE approved Legal Panel for Attorney selection

☐ SCORE does not have an approved Legal Panel for Attorney selection

☐ All Litigation to be handled by SCORE inhouse Legal

☒ GH always sends Litigation Assignment packets to Legal Counsel

SCORE specific Litigation Guidelines: ☒ Yes ☐ No

SCORE specific Litigation Referral Form/Letter: ☒ Yes ☐ No

SCORE specific Litigation Budget Form: ☒ Yes ☐ No

Pay fees for Experts, photocopies, medical records as: ☐ Expense ☐ Legal

EXCESS REPORTING:

☒ GH will report claims to the excess insurer in compliance with excess carrier's reporting requirements and coordinate with the excess insurer on a claim's progress in accordance with the excess insurer's reporting requirements.

☐ SCORE will report claims to the excess insurer in compliance with excess carrier's reporting requirements and coordinate with the excess insurer on a claim's progress in accordance with the excess insurer's reporting requirements.

AUTHORITY LEVELS:

Reserve Setting within SIR:

☐ $0.00 ☒ Other: $5,000 Adjuster must seek approval from (client contact) to post indemnity reserves above the amount indicated.

Settlement Authority

☒ $0.00 ☐ Other:_____ Adjuster must seek approval from (client contact) to consent to settlement of any claim at or above the amount indicated.

Medical Treatment:

☒ Medical Authorizations should only be sent to the claimant once liability is determined to be adverse to the SCORE.

☐ Medical Authorizations should go out as soon as it is determined that a BI claim is being pursued.

CLAIMS EXCEEDING SIR:

☐ GH stops tracking activity once the SIR has been reached.

☐ GH will continue to track all activity at and/or above the SIR. The Excess JPA/Carrier will provide GH with activity documentation above the SIR.

☒ GH will reserve to Full Value and track recoveries.

THIRD PARTY SUBROGATION SERVICES:

☒ GH must obtain authorization to initiate third party subrogation claims on behalf of SCORE.

FIRST PARTY SUBROGATION SERVICES:

☒ SCORE elects to incorporate the first party subrogation services of GH into the contract

☐ SCORE authorizes GH to initiate first party subrogation claims on behalf of SCORE

☐ SCORE agrees to the additional compensation payable to GH for its first party subrogation services as follows:

GH shall be entitled to 30% of the gross recovery for each claim initiated by GH through its first party subrogation efforts.

☐ SCORE agrees to the terms and conditions stated in Attachment A-1, Subrogation Services.

LAW ENFORCEMENT CONSULTING SERVICES

☐ SCORE agrees to the terms and conditions stated in Attachment A-2, Law Enforcement Consulting Services.

5/8/23
Date

BY: _____
John E. Chaquica, CEO
GEORGE HILLS COMPANY INC.

_____
Date

BY: _____
Wes Heathcock, President
SMALL CITIES ORGANIZED RISK EFFORT

ATTACHMENT A-1

FIRST PARTY SUBROGATION SERVICES

George Hills Co., Inc. ("GH") has agreed to provide first party subrogation services to the members of Small Cities Organized Risk Effort ("SCORE"), under the Claims Adjusting and Administration Services Contract executed by GH and SCORE. SCORE members ("MEMBER") will independently elect to utilize these services, as needed, individually, independently, and subject to the terms contained in this Attachment A-1.

1) MEMBER may authorize GH to act as a representative of MEMBER for the investigation, adjustment, processing, supervision, and evaluation of an ultimate recovery of potential money from the identified individuals or entities.

2) With prior approval of the MEMBER, GH my engage the services of one of the MEMBER's litigation attorneys to consult, review, and determine the best legal strategy available leading to recovery for the MEMBER. Upon determination by the attorney that a civil action is in the best interest of the MEMBER, GH will notify the MEMBER and obtain authorization to initiate litigation in accordance with the recommendations of the MEMBER and its attorney.

3) Where GH is able to recover money from an identified individual or entity, in addition to any other compensation identified in this contract, MEMBER will pay a Subrogation Fee in the amount of 30% of the gross amount recovered for each recovery obtained by GH. The minimum amount to be paid to GH will be $250 per claim upon recovery. However, GH has the authority to reject any claim for any reason, relieving the MEMBER of any fiscal responsibility for rejected claims only. The amounts due under this section shall invoiced to the MEMBER on a monthly basis following receipt of the recovery payment from the at-fault party.

4) While GH is handling a subrogation claim for the MEMBER pursuant to the terms of this Contract, and the institution of a civil action is determined by the MEMBER to be the best course of action, MEMBER may elect to, at MEMBER's expense, recall the claim to the MEMBER's control so that MEMBER may pursue recovery in a manner in the best interest of the MEMBER. In the event the MEMBER recalls the claim as indicated above, MEMBER shall be responsible for payment to GH for any and all time and expense incurred by GH's subrogation claim adjuster, and/or subrogation division staff, up to the time wherein the claim has been recalled by the MEMBER.

5) Where requested, GH shall consult with MEMBER on claims and other related matters not specifically assigned to GH for handling under this Contract.

6) GH reserves the right to cease working on any claim whereas information has not been made available to GH within 120 days after GH has submitted the information and/or documentation to the MEMBER, at such time, the claim will be closed.

7) Due to the nature of these services, in that compensation is contingent upon recovery, if the contract is terminated prior to recovery or other closure of any claim, the MEMBER shall pay GH for all expenses and time spent, to date, on any claims(s) currently open and recovery in process. Payment shall be based on the current hourly rate of GH of $95.00 per hour. GH will submit final invoice within five business days of termination.

8) All costs and expenses of litigation filed pursuant to this section, including attorney fees for outside counsel where necessary and approved, will be paid by the MEMBER.

9) GH does not handle subrogation claims with a value less than $1,000, unless a separate arrangement is established and agreed to..

10) Billing for Services and Payment to GH: The process preferred by GH is stated as follows:

A. Once recovery is agreed to between GH and the at-fault party and all documentation executed including a release, the at-fault party will issue a check to GH for the full agreed upon amount;

B. GH shall deposit the gross recovered funds into the GH Client Trust Fund.

C. Within ten (10) days after deposit, GH will issue the net payment to the MEMBER of the amount remaining after deduction of the fees to compensation GH based on this Contract.

11) General Terms and Conditions

A. Successors and Assigns.
All of the rights, benefits, duties, liabilities, and obligations of the parties shall inure to the benefit of, and be binding upon, their respective successors and assigns.

B. Construction.
The title and headings of the Sections in this Agreement are intended solely for reference and do not modify, explain, or construe any provision of this Agreement. All references to sections, recitals, and the preamble shall, unless otherwise stated, refer to the Sections, Recitals, and Preamble of this Agreement. In construing this Agreement, the singular form shall include the plural and vice versa. This Agreement shall not be construed as if it had been prepared by one of the parties, but rather as if both parties have prepared the Agreement.

C. Integration.
This Agreement, and all related documents referred to in this Agreement, constitute the entire Agreement between the parties. There are no oral agreements which are not expressly set forth in this Agreement and the related documents being executed in connection with this Agreement. This Agreement may not be modified, amended, or otherwise changed except by a writing executed by the party to be charged.

D. Third-Party Rights.
Nothing in this Agreement, express or implied, is intended to confer upon any person, other than the parties and their respective successors and assigns, any rights or remedies.

E. Severability.
If any term or provision of this Agreement is held invalid or unenforceable, the remainder of this Agreement shall not be affected.

F. Waivers.

No waiver or breach of any provision shall be deemed a waiver of any other provision, and no waiver shall be valid unless it is in writing and executed by the waiving party. No extension of time for performance of any obligation or act shall be deemed an extension of time for any other obligation or act.

G. Counterparts.
This Agreement may be executed in one or more counterparts, each of which shall be deemed an original and all of which taken together shall constitute one and the same instrument. The execution of this Agreement shall be deemed to have occurred, and this Agreement shall be enforceable and effective, only upon the complete execution of this Agreement by Seller and Purchaser.

H. Authority of Parties.
All persons executing this Agreement on behalf of a party warrant that they have the authority to execute this Agreement on behalf of that party.

I. Governing Law.
This Agreement shall be governed by and construed in accordance with California law.

5/8/23
Date

BY: _____
John E. Chaquica, CEO
GEORGE HILLS COMPANY, INC.

_____
Date

BY: _____
Wes Heathcock, President
SMALL CITIES ORGANIZED RISK EFFORT

ATTACHMENT B

MEDICARE, MEDICAID, AND SCHIP EXTENSION ACT OF 2007 (MMSEA)

This law requires liability insurers, self-insurers, no fault insurers and workers' compensation insurers to report certain information to The Centers for Medicare and Medicaid Services (CMS) concerning Medicare beneficiaries. The penalty for failure to comply is $1,000 per day, per claimant.

George Hills Company, Inc. (GH) has contracted with ExamWorks for Mandatory Insurer Reporting (MIR) for SCORE. ExamWorks shall represent the SCORE-and Responsible Reporting Entity (RRE) to this existing contract and this addendum and will be the designated reporting agent. GH will be responsible for gathering and reporting accurate claims data required by MMSEA to ExamWorks in a timely manner. GH agrees to assume the responsibility for reporting data to ExamWorks to meet all reporting requirements in accordance with MMSEA, on behalf of the RRE; including assuming responsibility for any fines or penalties that are directly caused by GH's non-compliance. GH further agrees to indemnify, defend and hold-harmless, RRE, and staff, for any penalties or fines resulting from GH's direct failure to timely and accurately provide the reporting data to ExamWorks. The above-mentioned obligations to indemnify, defend and hold-harmless shall not be applicable to matters relating to delays caused by RRE or other third parties, or inaccurate data supplied to GH by RRE or other third parties.

By contract with GH, ExamWorks will indemnify and hold GH harmless from and against any claim, damage, fine, loss and expense, arising in connection with, or as a result of, any error, omission, or negligent performance of its obligations as reporting agent, which indemnity will include all reasonable costs of litigation and attorneys' fees incurred. Without in any way limiting the indemnity set forth in this Contract, all work performed by ExamWorks will be done in a professional manner.

GH shall perform the necessary data gathering for RRE and ExamWorks; as such GH shall include in our monthly invoicing the time incurred for such work at our contract hourly rate or will be included in your monthly flat fee or claims adjusting.

ExamWorks will perform the MMSEA Mandatory Insurer Reporting function for GH, and its RREs, shall be charged as an Allocated Expense, as defined in Attachment C, subject to the following. RRE will designate ExamWorks, unless otherwise requested, as its exclusive vendor for all of RRE's "Qualified Referrals" (those claims determined to require Medicare Set Aside (MSA) or a Claim Settlement Allocation (CSA) and RRE will utilize other ExamWorks services related to Medicare Secondary Payer (MSP) compliance identified in their fee schedule.

ATTACHMENT C

PREFERRED METHOD OF CHECK PROCESSING

1. Selection of Bank

   a) ☐ GH uses CA Bank & Trust

   b) ☒ Clients Choice

      Name Wells Fargo

      Address Loomis

      Please provide signature cards, sample check, starting check number, name of contact person

2. Trust Balance Desired $_300,000_____

3. Account funding: GH will notify client when the balance falls below required balance

4A. Number of Signatures Required

   a) ☒ One

   b) ☐ Two on all checks

   c) ☐ Two on checks in excess of $_____

4B. If two signatures are required please specify:

   a) ☐ Both GH

   b) ☐ One GH, one client

      GH signers: John Chaquica, CEO; Chris Shaffer, COO;

5. Accountability

   a) Positive Pay: Yes ☒ No ☐

      GH recommends positive pay to mitigate the potential for fraud.

   b) Check Registers: Yes ☒ No ☐

      Weekly ☐ Monthly ☒

   c) ☐ Statement to be balanced by client, or

      ☒ Statement to be balanced by GH with copies to client

ATTACHMENT D

ALLOCATED EXPENSES

Typically, allocated expenses are those expenses that are generated by a claim (by outside vendors other than George Hills) that cannot be foreseen nor included in an agreement. These are generally allocated back to the specific claim file for which the cost was incurred and then charged back to the entity whose claim incurred that cost. In most situations are pass-through costs (with processing fees) for services and/or fees not directly generated by the TPA, but rather by a third-party consultant where the TPA has acted as an agent on behalf of the entity to necessarily outscore services to a third-party consultant and/or miscellaneous fees applicable to the specific claim applied by an outside entity, such as a court or copy service. Below, George Hills has provided a list, by no means an exhaustive list, of typical allocated expenses.

- Fees of outside counsel for claims in suit, coverage opinions, and litigation, and for representation and hearings or pretrial conferences;
- Fees of court reporters;
- All court costs, court fees, and court expenses;
- Fees for service of process;
- CMS reporting costs and fees (ExamWorks);
- Costs of undercover operatives and detectives;
- Costs for employing experts for the preparation of maps, professional photographs, accounting, chemical or physical analysis, or diagrams;
- Costs for employing experts for the advice, opinions, or testimony concerning claims under investigation or in litigation for which a declaratory judgment is sought;
- Costs for independent medical examination or evaluation for rehabilitation;
- Costs of legal transcripts of testimony taken at coroner's inquests, or criminal or civil proceeding;
- Costs for copies of any public records or medical records;
- Costs of depositions and court reporting;
- Costs and expenses of subrogation, (if not George Hills);
- Costs of engineers, handwriting experts, or any other type of expert used in the preparation of litigation or used in a one-time basis to resolve disputes;
- Witness fees and travel expenses;
- Costs of photographers and photocopy services (if not George Hills—our costs for this is included in our rate);
- Costs of appraisal fees and expenses not included in flat fee or performed by others;
- Costs of indexing claimants;
- Services performed outside the TPA's normal geographical regions;
- Costs associated with Medicare Set-Aside analysis and submission or Medicare Conditional Lien negotiation;

- Investigation of possible fraud including SIU services and related expenses; and/or
- Any other similar cost, fee, or expense that is not otherwise included in the TPA's service fees that is reasonably chargeable to the investigation, negotiation, settlement, or defense of a claim or loss or to the protection or perfection of the subrogation rights of the entity, including any travel related expenses.

ATTACHMENT E

BUSINESS ASSOCIATE AGREEMENT BETWEEN THE SMALL CITIES ORGANIZED RISK EFFORT (SCORE) AND GEORGE HILLS COMPANY, INC.

This Business Associate Agreement ("BAA") is made and entered into this July 1st of 2023 by and between the SMALL CITIES ORGANIZED RISK EFFORT, hereinafter referred to as "SCORE," and GEORGE HILLS COMPANY, INC., hereinafter referred to as "GH."

I. RECITALS

WHEREAS, on or about date referenced above, GH entered into a written contract with SCORE to perform obligations and services related to the handling and administration of general liability claims filed against or with SCORE.

WHEREAS, the obligations of the Contract require that SCORE provide to GH date, documents, and information which may contained protected health information ("PHI") and/or electronic PHI ("ePHI") within the definition of the Health Information Portability and Accountability Act ("HIPAA") related to the general liability claims, for the purpose of administering those claims.

NOW, THEREFORE, in consideration of the mutual promises of the parties and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the PARTIES hereto agree as follows:

II. DEFINITIONS

Catch-all definition:

The following terms used in this AGREEMENT shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

Specific definitions:

(a) Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean GEORGE HILLS COMPANY, INC.

(b) Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean SCORE.

(c) HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

III. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

Pursuant to this agreement GH agrees to:

(a) Not use or disclose protected health information other than as permitted or required by the Agreement or as required by law;

(b) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of protected health information other than as provided for by the Agreement;

(c) Report to covered entity any use or disclosure of protected health information not provided for by the Agreement of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR 164.410, and any security incident of which it becomes aware;

(d) In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information;

(e) Make available protected health information in a designated record set to the GH as necessary to satisfy covered entity's obligations under 45 CFR 164.524;

(f) Make any amendment(s) to protected health information in a designated record set as directed or agreed to by the covered entity pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy covered entity's obligations under 45 CFR 164.526;

(g) Maintain and make available the information required to provide an accounting of disclosures to the GH as necessary to satisfy covered entity's obligations under 45 CFR 164.528;

(h) To the extent the business associate is to carry out one or more of covered entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligation(s); and

(i) Make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules.

///

IV. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

(a) Business associate may only use or disclose protected health information for the purposes described in the Contract between GH and SCORE, specifically for the purpose of adjusting and administering the general liability claims filed against SCORE.

(b) Business associate may use or disclose protected health information as required by law.

(c) Business associate agrees to make uses and disclosures and requests for protected health information consistent with covered entity's minimum necessary policies and procedures.

(d) Business associate may not use or disclose protected health information in a manner that would violate Subpart E of 45 CFR Part 164 if done by covered entity [if the Agreement permits the business associate to use or disclose protected health information for its own management and administration and legal responsibilities or for data aggregation services as set forth in optional provisions (e), (f), or (g) below, then add ", except for the specific uses and disclosures set forth below."]

(e) Business associate may use protected health information for the proper management and administration of the business associate or to carry out the legal responsibilities of the business associate.

(f) Business associate may disclose protected health information for the proper management and administration of business associate or to carry out the legal and contractual responsibilities of the business associate, provided the disclosures are required by law, or business associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies business associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(g) Business associate may provide data containing PHI and or ePHI to third party entities for storage, security, and/or aggregation services relating to the claims administration services provided by GH.

V. PROVISIONS FOR COVERED ENTITY TO INFORM BUSINESS ASSOCIATE OF PRIVACY PRACTICES AND RESTRICTIONS

(a) Covered entity shall notify business associate of any limitation(s) in the notice of privacy practices of covered entity under 45 CFR 164.520, to the extent that such limitation may affect business associate's use or disclosure of protected health information.

(b) Covered entity shall notify business associate of any changes in, or revocation of, the permission by an individual to use or disclose his or her protected health information, to the extent that such changes may affect business associate's use or disclosure of protected health information.

(c) Covered entity shall notify business associate of any restriction on the use or disclosure of protected health information that covered entity has agreed to or is required to abide by under 45 CFR 164.522, to the extent that such restriction may affect business associate's use or disclosure of protected health information.

VI. PERMISSIBLE REQUESTS BY COVERED ENTITY

Covered entity shall not request business associate to use or disclose protected health information in any manner that would not be permissible under Subpart E of 45 CFR Part 164 if done by covered entity.

VII. TERM AND TERMINATION

(a) Term. The Term of this Agreement shall be effective as of date referenced above and shall terminate on the date which SCORE terminates for cause as authorized in paragraph (b) of this Section, whichever is sooner.

(b) Termination for Cause. Business associate authorizes termination of this Agreement by covered entity, if covered entity determines business associate has violated a material term of the Agreement and business associate has not cured the breach or ended the violation within the time specified by covered entity.

(c) Obligations of Business Associate Upon Termination.

Upon termination of this Agreement for any reason, business associate, with respect to protected health information received from covered entity, or created, maintained, or received by business associate on behalf of covered entity, shall:

Retain only that protected health information which is necessary for business associate to continue its proper management and administration or to carry out its legal and contractual responsibilities;

Return to covered entity, or destroy, the protected health information that the business associate maintains in any form;

Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information to prevent use or disclosure of the protected health information, other than as provided for in this Section, for as long as business associate retains the protected health information;

Not use or disclose the protected health information retained by business associate other than for the purposes for which such protected health information was retained and subject to the same conditions set out above under "Permitted Uses and Disclosures By Business Associate" which applied prior to termination; and

Return to covered entity, or destroy, the protected health information retained by business associate when it is no longer needed by business associate for its proper management and administration or to carry out its legal and contractual responsibilities.

(d) Survival. The obligations of business associate under this Section shall survive the termination of this Agreement.

5/8/23
Date

BY: _____
John E. Chaquica, CEO
GEORGE HILLS COMPANY INC.

_____
Date

BY: _____
Wes Heathcock, President
SMALL CITIES ORGANIZED RISK EFFORT

INTERCARE WORKERS' COMPENSATION CLAIMS ADMINISTRATION AGREEMENT 2023-2026

ACTION ITEM

ISSUE: Intercare has provided the attached proposal for services with for three years (FY 23/24 through FY 25/26), with an optional three years (FY 26/27 through FY 28/29). Legal counsel has reviewed and provided feedback on the final draft.

RECOMMENDATION: Approve the proposed agreement based on Board direction.

FISCAL IMPACT: See below table for schedule of annual admin fees.

One-time Onboarding Fee - $1,500
One-time Custom/Complex Lay out Fee - $500
Monthly maintenance fee per interface - $100

CLAIMS ADMINISTRATION FEE (Fixed Per Year)[a] Base Contract	Fixed Flat Fee
Year 1: 7/1/2023-6/30/2024	$ 108,495.60
Year 2: 7/1/2024-6/30/2025	$ 111,750.47
Year 3: 7/1/2025-6/30/2026	$ 115,102.98
Option Years:	
Year 4: 7/1/2026-6/30/2027	$ 118,556.07
Year 5: 7/1/2027-6/30/2028	$ 122,112.75
Year 6: 7/1/2028-6/30/2029	$ 125,776.14

BACKGROUND: Sedgwick (formally York Risk Services) has provided claims services for SCORE members since inception of the Liability and Workers' Compensation Programs. At the March 31, 2023, the Board provided direction to select Intercare as the Workers' Compensation claims administrator after a Request for Proposal process was completed in 2023.

ATTACHMENT(S): Intercare Agreement 2023-2026

WORKERS' COMPENSATION CLAIMS ADMINISTRATION SERVICE AGREEMENT

This Service Agreement is effective July 1, 2023 by and between Intercare Holdings Insurance Services Inc., a California corporation (**"IHI"**), and Small Cities Organized Risk Effort (Client), a private self-insured Joint Powers Authority (**"Client"**).

RECITALS

A. Client desires to have specific claims administration and cost containment services performed by IHI in accordance with applicable laws and regulations in connection with Client's Workers' Compensation Program.

B. IHI has developed and manages certain health care management products and services including claims administration, telephonic case management, utilization review and bill review.

C. IHI is willing to provide such services on the terms and conditions hereinafter stated.

NOW THEREFORE, in consideration of the mutual covenants, agreements, representations, and warranties contained in this Agreement, the parties agree as follows:

AGREEMENT

1. Terms. This Service Agreement shall be for the period set forth below except as may be amended or canceled as hereinafter provided.

1.1. This Agreement is effective July 1, 2023 and shall continue to be in force for three years through June 30, 2026 (the **"Initial Term"**). If this Agreement is not terminated or the term not modified in accordance with the terms of this Agreement, this Agreement shall be renewed automatically for successive twelve month periods thereafter for an additional three year term and continue (each a **"Renewal Term"**).

1.2. Notwithstanding the foregoing, in the event CLIENT requests in writing that INTERCARE continue to provide any services for claims reported hereunder after the expiration or cancellation hereof, this Agreement shall remain in effect to govern the parties' respective rights and obligations with respect to the services for claims reported.

2. Definitions. In addition to the various terms defined in the body of this Agreement, the following capitalized terms shall have the meanings given below:

2.1. **"Agreement"** means this document and any amendments or schedules attached hereto from time to time including, without limitation, any amendments or schedules for terms and conditions that may have been renewed.

2.2. **"Allocated Loss Expenses"** shall mean, in addition to fees to be paid in accordance with items listed or inferred herein Agreement, all reasonable expenses necessary to the adjustment of a claim in accordance with this Agreement, including but not limited to all costs, charges, or expenses of third parties incurred by IHI, its agents, employees or officers that are incurred in connection with or related to a Claim including, without limitation, the following:

2.2.1 court costs, fees and expenses of attorneys, court reporters, investigators (including, without limitation, undercover operatives and detective services), experts and witnesses, and fees for obtaining diagrams, reports, documents, and photographs;

2.2.2 pre and post-judgment interest paid as a result of litigation;

2.2.3 fees for service of process;

2.2.4 costs of legal transcripts of testimony taken at coroners' inquests or from criminal or civil proceedings;

2.2.5 costs of copies of any public records and/or medical records;

2.2.6 costs of independent medical examinations and/or evaluations for rehabilitation and/or to determine the extent of the Claimant's and/or the Client's liability;

2.2.7 costs of independent field examiners and related expenses to investigate a claim;

2.2.8 costs of all Cost Containment Services (defined on Exhibit A attached hereto) including but not limited to: medical bill review or adjudication including network related expenses and independent bill review fees; medical management expenses related to medical cost containment efforts including, without limitation, utilization review provided by clinical staff including peer review including fees associated with the request for Independent Medical Review; nurse case management including telephonic or field case management;

a. Prior authorization is an arrangement written into the UR plan that describes the specific conditions or circumstances under which a treating physician will be assured of appropriate reimbursement for specific treatment, without submitting an RFA before, during or after the treatment. As long as that treatment fits the description of prior authorization in the UR plan, the treating physician may treat and then submit the bill for payment.

b. A Request for Authorization (RFA) is a form that a medical provider is required to use to request treatment, diagnostic tests or other medical services for an injured worker. If the treatment request was first made verbally, it must be confirmed in writing. The treating physician must fill out the form and attach the doctor's first report of occupational injury or illness (form 5021), the primary treating physician progress report (DWC form PR-2), or a narrative report that contains the same information required in the primary treating physician progress report form. As used in this Agreement, an RFA is defined as a request from a healthcare professional either through the RFA Form or as contained in a single medical report. An RFA may have multiple treatment modality. Some treatment modality may be authorized by a non-clinician such as the Adjuster and others may be referred to a Utilization Review Organization ("URO") depending on the Client's Protocol and Utilization Review Guidelines and in such instances when the treatment plan may need to be delayed, modified or denied.

c. A Peer Advisor is a Licensed Healthcare Professional who is in the same licensing category (MD, DO, DC) as the provider requesting authorization for the treatment, who is trained in occupational medicine and can examine treatment plans and provide objective and unbiased determinations on the necessity of the treatment plan.

d. A Specialty Review is a utilization review conducted by a Peer Reviewer licensed in the same field of specialization as the healthcare professional requesting the authorization for treatment. The distinction here is that the area of specialization of the Peer Advisor conducting the review must match the specialty of the healthcare professional requesting the treatment.

2.2.9 any other similar costs, fees or expenses reasonably chargeable to the investigation, negotiation, settlement or defense of a Claim or loss or to the protection of the subrogation rights of Client;

2.2.10 costs of interpreters;

2.2.11 costs of credit bureau and index reports;

2.2.12 costs related to the special investigation of fraudulent claims; and

2.2.13 safety and loss control services.

2.2.14 Upon agreement with the CLIENT, INTERCARE may, but need not, elect to utilize its own staff to perform these services.

2.3. **"Claim"** means a request made by Client for the receipt of benefits under the Insurance Program.

2.4. **"Claim File"** means the administrative record of a Claim, including, without limitation, the accounting of expenses related to a Claim.

2.5. **"Claimant"** means any employee insured by Client and entitled to coverage under the Insurance Program.

2.6. **"Qualified Claim"** means a Claim entitled to receive benefits under the Insurance Program.

2.7. **"Indemnity Claim"** means a Qualified Claim including, without limitation, one or more of the following elements:

2.7.1 the injured employee's time off work due to a compensable or potentially compensable injury meets the applicable jurisdictional waiting period;

2.7.2 coverage issues;

2.7.3 issues of compensability;

2.7.4 requires subrogation investigation;

2.7.5 modified duty is provided for more than 12 weeks, or which has or may result in any of the following benefits:

a. Temporary disability or salary in lieu thereof

b. Permanent Disability

c. Life Pension

d. Death Benefits

e. Vocational Rehabilitation

f. Supplemental Job Displacement Voucher Benefits

2.7.6 results in an award of either permanent partial or permanent total disability benefits regardless of whether the jurisdictional waiting period is met or not; and

2.7.7 results in a Petition for Adjudication of Claim being filed before the applicable state agency even if no benefits are awarded.

2.8. **"Future Medical Claim" means a Qualified Claim including, without limitation, one or more of the following elements:**

2.8.1 An Indemnity claim which has been concluded and resulted in an award of permanent partial or permanent total disability benefits along with a provision for "future medical treatment" provided the permanent partial or permanent total disability award has been satisfied and no ongoing indemnity payments is being paid;

2.8.2 An Indemnity claim, which has been resolved and is open only for purposes of administering the future medical provision of the award, provided the medical payment activity does not exceed three times per year.

2.9. **"Medical Only Claim"** means a Qualified Claim including, without limitation, one or more of the following elements:

2.9.1 a work-injury case that does not result in compensable lost time but results in medical treatment beyond first aid.

2.9.2 any workers' compensation claim where the only issue is payment of medical bills for reasonable and necessary care or treatment;

2.9.3 the total amount paid on the claim for medical care or treatment is $3,000 or less;

2.9.4 no investigation is needed to determine compensability of the claim.

2.9.5 time off work due to a potentially compensable injury does not meet the jurisdictional waiting period;

2.9.6 there is no exposure for permanent partial or permanent total disability benefits; and

2.9.7 where modified duty is provided for no longer than 12 weeks

2.9.8 Indemnity benefits are not due or potentially due

2.9.9 Conversion Rule – claim may be converted to indemnity if one or more of the following:

a. Total cost of medical care exceeds $3,500 and is not ready for immediate closure when the dollar amount pierces the threshold;

b. claim has been opened for 180 days or more; and

c. additional investigation is needed to determine compensability of claim even if injured worker is not losing time or additional investigation is needed to determine subrogation status.

2.10. **"Asbestos Claim"** means a Qualified Claim including, without limitation, one or more of the following elements:

2.10.1 Any Workers' Compensation claim resulting from a disease or illness caused by continuous exposure to some deleterious substance, microorganism or harmful substances in the course of employment provided Client is not the leading defendant.

2.11. **"First Aid"** means **"**any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, and so forth, which do not ordinarily require medical care. Such one-time treatment and follow-up visit for the purpose of observation is considered first aid even though provided by a physician or registered professional personnel." Insured employer in California are required to report all claims for which medical treatment costs are incurred including first aid claims. First aid claims are created as a medical only claim and reported to the carrier along with the associated costs. The carrier is responsible for reporting these claims to WCIRB.

2.12. **"Incident Only"** means a claim for which an incident is reported with no medical attention or if medical attention is provided, it is administered immediately after the injury occurs and at the location where it occurred with no associated medical cost.

2.13. **"Services"** means a collective reference to the products and/or services set forth in this Agreement to be provided by IHI.

2.14. **"Service Fees"** means a collective reference to the various fees to be paid by Client to IHI pursuant to this Agreement.

2.15. "**Solvent**" means, when used with respect to either party, that (a) such party is not "insolvent" within the meaning of 11 U.S.C. Section 101(32) and the cases interpreting the same; (b) such party is generally able to pay its debts as they become due; and (c) such party does not have unreasonably small capital to carry on such party's business as theretofore operated and all businesses in which such party is about to engage.

2.16. **"Insurance Program**" means the insurance program established by Client to provide workers' compensation benefits to employees of Client's employer members as set forth under the rules, ordinances and provisions of Client.

3. Services To Be Performed by IHI. IHI agrees to perform, and shall provide, each of the following Services on the terms set forth herein and in Exhibit A attached hereto:

3.1. Claims Administration Services. IHI shall:

3.1.1 review each Claim received from Client and process each such Claim in accordance with the Insurance Program's statement of work;

3.1.2 conduct an investigation of each reported Claim to determine on behalf of Client for each reported employee injury or illness those benefits, if any, that should be rendered under the Insurance Program. Any Claim believed to be fraudulent shall be referred to IHI's in-house special investigative unit for further investigation, and the unit shall with the prior approval of Client determine whether such Claim is required to be submitted to the applicable District Attorney's Office or United States Attorney;

3.1.3 establish and maintain an electronic record file for each Claim;

3.1.4 maintain an average Caseload of 150 cases or less per Indemnity Adjuster. The average Indemnity caseload shall not exceed 150 cases in any given quarter. In the event that the frequency of new claims increases to a level that warrants the addition of staff to maintain the caseload requirements, IHI and Client shall agree to evaluate the caseload for a period of at least three consecutive months before adjusting the number of staff accordingly. Caseload shall be defined by the number of indemnity and future medical cases open on the last day of each calendar month.

3.1.5 arrange for and retain independent investigators or medical or other experts, to the extent deemed necessary or desirable by IHI, in connection with processing any Claim;

3.1.6 maintain an estimate of the total costs of all reasonable and foreseeable benefits payable and related expenses on each Qualified Claim based upon the facts and circumstances known at the time and update the same on regular and periodic basis;

3.1.7 pay medical and death benefits, temporary and permanent disability compensation and other losses and expenses on Qualified Claims (a) if, in the judgment of IHI, such payment would be prudent for Client and (b) pursuant to the terms of this Agreement or as may be approved by Client in its sole and absolute discretion;

3.1.8 perform reasonable and necessary administrative and clerical work in connection with Claims including the preparation of checks drawn on the account or accounts established by, or at the direction of, Client;

3.1.9 assist in connection with Client's selection of defense counsel to defend Qualified Claims or losses, if requested by Client;

3.1.10 assist Client's selected defense counsel in preparing the defense of litigated Claims, negotiating settlements, and pursuing subrogation or contribution actions;

3.1.11 (a) oversee the treatment programs recommended for Claimants by physicians, medical specialists, and other health care providers by reviewing all reports prepared

by such providers and maintaining such contact with such providers as may be appropriate in the judgment of IHI; and (b) manage the medical treatment in accordance with Insurance Program;

3.1.12 prepare and file on behalf of Client all forms related to the processing of Claims that are required by the Insurance Program or government agencies except for MMSEA filings which shall remain the responsibility of the Client;

3.1.13 provide Client with standard computerized reports, including, but not limited to, monthly loss run and payment registers, and statistical reports; if additional reports, special reports, conversion or special programming or information is needed, the cost payable by Client for such additional items will be limited to costs actually incurred by IHI to prepare such items; Client may specify from the list of available reports which reports will be sent to them on a regular basis;

3.1.14 provide initial claims forms packets as deemed appropriate by IHI for efficient administration of Claims in compliance with the Insurance Program; and

3.1.15 comply with Client's service instruction guidelines for the administration of the Services as such Services are set forth in this Agreement.

3.2. Medical Expense Control and Managed Care. IHI shall provide information to ill or injured Claimants regarding the benefits available under the Insurance Program and counsel any Claimants who wish to obtain the assistance of third parties for work-related illnesses or injuries.

3.3. Claims Counseling. IHI shall:

3.3.1 consult with key personnel of Client on the establishment and coordination of necessary procedures and practices to meet any needs of Client with respect to the administration and processing of Claims;

3.3.2 participate in the orientation of Client's personnel who are directly or indirectly involved in the processing of Claims;

3.3.3 provide information on changes or proposed changes in legislation, rules or regulations affecting the responsibility of Client with respect to Claims; and

3.3.4 review the development of the Insurance Program periodically with representatives of Client in order to identify problems and recommend corrective action.

3.3.5 provide training sessions annually to the Client including Basic Workers' Compensation Guidelines and Fraud Detection.

3.3.6 Medical Control Services. IHI shall:

3.3.7 assist Client, where permitted, in the selection of (a) a medical provider network and panel of physicians or other health care providers to initially treat Claimants and (b) a medical provider network and panel of medical specialists to provide long-term or specialty care;

3.3.8 where appropriate, assist Client with the interpretation of medical reports to consider the circumstances under which an ill or injured Claimant, who desires to do so, could return to work in the shortest period of time;

3.3.9 endeavor to utilize telephonic medical case management services when warranted using IHI's Managed Care Division, InterMed ; and

3.3.10 adjudicate medical/provider billings in accordance with a fee schedule comparable to the Official Medical Fee Schedule or Client's direct contract(s) with provider(s) using InterMed.

3.4. Medical Management Services. IHI, through its Managed Care Division, InterMed Cost Containment services, shall provide:

3.4.1 New Claim Triage services if applicable;

3.4.2 PPO network direction and negotiation;

3.4.3 Utilization review including surgical pre-certification;

3.4.4 Disability management; and

3.4.5 Telehealth services if applicable.

3.5. Standard Bill Review Services. IHI, through its Managed Care Division, InterMed Cost Containment services, shall:

3.5.1 Auto adjudication of medical bills and/or line-by-line audit of all procedures billed by medical providers; outpatient hospitalization audits, including all ambulatory surgical services; inpatient fee hospitalization audits and reviews; medical/legal bills and ancillary services that may need to be reported to a regulatory agency such as invoices for translation and interpreting services, copy service and other services required by regulatory agencies; and

3.5.2 Comply with Statutory regulation by integrating data feeds from the bill review application and claims management system into the applicable jurisdiction's electronic data interface (EDI) feed to comply with the EDI mandate for medical bill/payments.

3.6. Medicare, Medicaid and State Children's Health Insurance Program Extension Act of 2007 (MMSEA) Section 111 Mandatory Reporting.

3.6.1 To assist Client in fulfilling its mandatory Medicare beneficiary reporting obligations under the MMSEA Section 111 as set forth in 42 USC 139(b)(7)&(8) and the Center for Medicare Services (CMS) User Guide published March 16, 2009 and as amended and revised periodically by CMS, IHI will perform the following reporting services:

a. IHI will establish an electronic interface with CMS to capture and report data in the format prescribed by the CMS User Guide Specifications.

b. IHI will report directly to CMS on behalf of Client as an Account Designee (reporting agent), as such term is defined in the CMS User Guide as amended from time to time by CMS.

c. Client will be considered a Responsible Reporting Entity (RRE) as that term is defined in the CMS User Guide. Client will be responsible for maintaining a valid RRE Identification Number as described in the CMS User Guide and is a condition precedent to IHI performing the duties under this section. Failure to maintain the RRE Identification Number will result in IHI's inability to properly report claims on behalf of Client. IHI assumes no responsibility for maintaining a valid RRE Identification Number on behalf of Client.

3.6.2 IHI will further assist Client by collecting the legal name, social security number, gender, date of birth of the Medicare Beneficiary; prepare required data files and submit to CMS on a periodic basis eligibility query and quarterly report the appropriate claims as defined in the CMS User Guide on the RRE's designated reporting group.

3.6.3 IHI will be responsible for fines assessed to Client in connection with the MMSEA beneficiary reporting requirement that relate to IHI's negligent acts or omissions except to the extent that:

a. Such fines and penalties are the direct result of specific direction given by Client and/or its agent or the actions or omissions of Client and/or its agent; or

b. IHI did not receive information/received incorrect information from Client that is essential to the performance of the duties set forth herein in a timely manner so as to be able to comply with the terms of this Agreement.

3.6.4 Provide evidence of Quarterly report submitted to CMS on behalf of CLIENT.

3.7. Additional Services. IHI shall periodically meet with Client and IHI shall agree to provide such additional claim administration services as may be required from time to time for such additional Service Fees as may be agreed upon.

3.8. IHI shall be available to discuss the Program with CLIENT monthly and to provide standard loss reports at each of these meetings as may be reasonably requested.

4. Client Obligations to IHI. Client agrees to undertake and perform all of the following tasks:

4.1. Client shall pay Intercare the fees and related expenses as provided herein per the terms of Exhibit A attached hereto and incorporated herein.

4.2. encourage all employees to promptly report all relevant injuries or illnesses in writing to IHI;

4.3. promptly forward the form Employer's Report of Injury or Illness or similar document, all letters, correspondence, or any other information, whether oral or written, received by Client which is or could be relevant to the efficient and proper handling of any Claim;

4.4. fully cooperate with IHI in the performance of this Agreement;

4.5. provide IHI with any necessary data within Client's possession or control to enable IHI to perform under this Agreement; and

4.6. establish a zero balance account to pay claim related expenses in a timely manner.

4.7. Client shall contract directly with a prescription benefit management service, and such provider shall be capable of providing electronic data which is compatible with IHI's electronic claims record system.

4.7.1 If client is participating in IHI's PBM program, prescription bills for participating pharmacies shall not be subject to a bill review fee provided the PBM Network is Intercare's preferred vendor in which case the CLIENT shall receive the network discount for the drug cost and allowable dispensing allowance.

4.7.2 IHI shall endeavor to convert out of network prescription bills by referring non participating pharmacies to the PBM Network.

5. Discretionary Disbursement Authority Limit of IHI.

5.1. Disbursements. The aggregate limit on any discretionary payment by IHI for a Claim together with the individual Allocated Loss Expenses shall be $ 25,000. Client may increase this amount at any time upon giving prior written notice to IHI. It is agreed that IHI shall have full financial authority and control in all matters pertaining to the payment, processing, investigation and administration of Claims within the limits established by this Section.

5.2. Settlement Authority. IHI shall request authorization from Client prior to any settlement.

5.3. IHI Funds. It is expressly understood that IHI shall not be required to (a) advance IHI's own funds to pay Claims or Allocated Loss Expenses or (b) perform any Services hereunder if Client fails to provide adequate funds or funds in a timely manner as herein set forth.

6. Termination and Cancellation

6.1. Termination.

6.1.1 Breach. If IHI or Client fails to comply with or perform when due any term or condition of this Agreement, the other party shall notify the defaulting party of its default in writing, and the defaulting party shall have ninety days to cure the default; provided, however, notwithstanding the foregoing, Client shall be required to cure any default relating to the payment of Service Fees within thirty days of its due date. If the default is not so cured to a reasonable degree, the non-defaulting party may declare, in writing and without further notice, that this Agreement is terminated. Additionally, this Agreement shall terminate immediately, upon written notice of either party to the other party, in the event of the passage of a law or promulgation of a regulation or an action or investigation by any regulatory body which would (a) materially and adversely affect such party's rights and obligations hereunder or (b) prohibit the relationship between the parties or the operations of the parties hereunder.

6.1.2 Without Cause. Client and IHI will have the right to terminate this Agreement without cause by giving ninety (90) days prior written notice to the other party of its intention to terminate pursuant to this provision, specifying the date of termination. Client will

pay to IHI the compensation earned for work or services performed and not previously paid for through the date of closing.

6.1.3 No Effect. Termination of this Agreement shall have no effect on the rights and obligations of the parties arising out of any transaction occurring on or prior to the date of such termination. Client shall continue to fulfill its obligations to IHI under this Agreement that is pending on the date of termination. And IHI shall continue to fulfill its obligations to Client under this Agreement that are pending on the date of termination.

6.1.4 Bankruptcy. Either party may terminate this Agreement immediately upon written notice to the other party in the event that (a) the other party files a petition for reorganization under the provisions of federal bankruptcy laws or similar laws of another jurisdiction, (b) a receiver of all or substantially all of the property of the other party is appointed and not removed within thirty days, (c) the other party's business is no longer Solvent or (d) the other party is convicted of fraud, embezzlement or other

6.1.5 Options on Termination. Once Services are commenced by IHI hereunder for a Claim, they shall continue until the Claim is finally closed or until this Agreement expires, cancels or terminates, whichever occurs first. In the event of any expiration, cancellation or termination of this Agreement, IHI will, upon request from Client and at Client's expense, promptly transfer all pending and closed Claims to either Client or another administrator.

6.1.6 Termination Transfer Policy.

a. Post-Termination Processing of Claims. If requested by Client, IHI shall continue to process any qualified claims or losses remaining open at the termination plus any other claims received with occurrence dates that fall within the period or periods of this Agreement provided that the Client shall continue to make adequate funds available for the payment of such qualified claims or losses and any allocated loss expenses. The additional administrative fee(s) for this service shall be negotiated and agreed to prior to the effective date of termination.

b. Post-Termination File Maintenance/Disposal. Upon cancellation of this Agreement, IHI shall deliver, at Client's sole cost, the files IHI has maintained for qualified claims or losses except those IHI will continue to process (but not including any computer hardware, firmware, software or proprietary information of IHI); provided, however, as follows:

(i) Claims Data. Upon request of Client, IHI shall additionally provide file information using computer disks, flash drives, or secure file transfer protocol (SFTP). All data transfer will be encrypted using shared keys. The selection of usage of computer disks, flash drives, or SFTP shall be at the discretion of IHI. Such disks, flash drives, or SFTP transfer shall be produced at the sole expense of the Client.

(ii) Continued Inspections. IHI or its agents, employees or attorneys shall continue to be entitled to inspect such files and make copies or extracts there from.

(iii) Option to Retain or Destroy. IHI shall give Client thirty (30) days prior written notice of its intent to transfer files to Client. If Client does not agree to accept these files within such period, the files will be retained for an additional ninety (90) days or destroyed at IHI option. The Client shall have no recourse against IHI for failure to retain or the destruction of the files.

(iv) Client Records. On termination of this Agreement, IHI shall promptly surrender to the Client all records that in any way pertain to the business of the Client or to any of its members, including claims, files, invoices, manuals, and other written, printed, or computer-stored information pertaining to the Client. It is agreed that the Client owns all records that in any way pertain to the business of the Client. Client shall be responsible for all cost related to the transfer of records.

7. Practice of Law. It is understood and agreed that IHI shall not perform, and Client will not request performance of any services by IHI that may constitute the unauthorized practice of law.

8. Indemnification.

If IHI, its Agents, Employees, Representatives, or Assigns, negligently or intentionally violate any law or regulation, or any provision of the Agreement, proposer shall indemnify, defend, and hold Client harmless from and against all loss and damage, including any reasonable costs or expenses (including Attorney's Fees), incurred by Client in connection with such conduct.
IHI shall hold harmless and indemnify Client, its members, their officers and employees from every claim or demand made by reason of:

a. Any injury to person or property sustained by the proposer or by any person, contractor, or corporation employed directly or indirectly by the proposer upon or in connection with performance under the Agreement, however caused;

b. Any injury to person or property sustained by any person, firm, or corporation, caused by any act, neglect, default, or omission of IHI, or by any person, firm or corporation directly or indirectly employed by IHI upon or in connection with performance under the Agreement; and,

c. IHI at its own expense and risk shall defend any legal proceeding that may be brought against Client, its members, their officers, agents, and employees on any such claim or demand as set forth in paragraph a. and b. above of this subsection and pay and satisfy any judgment that may be rendered against Client and IHI as it pertains to this subsection.

IHI will indemnify Client for payment of any penalties incurred because of claims management related errors and omissions. This includes but is not limited to errors incurred because of failure to properly comply with reporting under Medicare section 111 except as outlined under 3.6.3, failure to timely provide benefits to injured workers, or the inappropriate or unnecessary overpayment of benefits.

8.2. Notice to Indemnifying Party. If a party (the "Indemnitee") receives written notice of any claim or the commencement of any action or proceeding with respect to which another party (the **"Indemnifying Party"**) is obligated to provide. Indemnitee shall (a) provide the Indemnifying Party written notice thereof, (b) tender control of the defense of the indemnified claim to the Indemnifying Party and once tender of control of the defense occurs, the indemnifying party shall make no settlement, compromise or otherwise resolve the claim in any manner which would injure in any way, the Indemnitee, and (c) not settle or otherwise resolve the indemnified claim without the prior written consent of the Indemnifying Party. In any event, the Indemnitee and the Indemnifying Party shall cooperate in the compromise of, or defense against, any such claim.

8.3. Determination of Defense and Indemnity Obligations. The Client and IHI agree that a determination of the defense and indemnity obligations as set forth in this Provision shall be based upon the following:

8.3.1 If the conduct complained of involves any alleged act, error, or omission, including any intentional tort, willful misconduct, negligence or gross negligence by Intercare or its directors, officers, or employees, arising out of or in any way related to Intercare's obligations under the terms of this Service Agreement, other than any action taken by Intercare for or at the specific direction of Client, including any allegations, demands, actions, damage, loss, costs and/or expenses whatsoever, as specified above, under this Agreement, Intercare shall defend and indemnify Client as set forth above. In such event Intercare shall have the right to select, with the prior consent of Client, such consent not to be unreasonably withheld, the attorneys to conduct the defense and Intercare and such attorneys shall have the right to direct the conduct of such defense.

8.3.2 If the alleged wrongful conduct cannot be determined from the allegations as pleaded, each party shall defend itself until the conduct complained of is clarified during the course of the litigation, at which time the defense and indemnity obligation shall promptly be determined in accordance with the terms of this provision; provided, however, in the event it is determined that one party is obligated to indemnify the other party, the party shall promptly reimburse other party for any fair and reasonable fees and expenses incurred by the other party up to the time of such determination.

9. IHI Claim Administration Standards.

9.1. Claim Files. Except tail claims transferred in hard copy files, IHI shall maintain all open claims and new claims electronically including all claim related documents received.

9.1.1 All Claim Files shall be available for review by Client during business hours.

9.1.2 IHI shall store closed files in hard copy format up to 7 years. Thereafter, closed hard copy files will be purged and destroyed. IHI shall notify CLIENT before the destruction date and provide CLIENT the option to ship files to CLIENT for storage or pay for ongoing storage.

9.2. Reports. Subject to the accuracy of the information provided to IHI, IHI agrees that loss reports provided to Client shall be accurate in all material respects, including, but not limited to, total Claim value, payments made to date and allocation to the proper Client facility.

9.3. Diary System. IHI shall utilize a computer generated diary system to provide ongoing file maintenance and facilitate review.

9.4. Service Instruction Guidelines. IHI and CLIENT shall develop and maintain a Service Instruction Guideline to supplement the contract as a working document outlining the ongoing service instructions to be followed by IHI and the claims team.

9.5. Prompt Payments. Client agrees to report all Claims to IHI within five days of Client's knowledge of such Claim. IHI agrees to make every reasonable commercial effort to disburse disability payments within fourteen days of the date on which IHI receives a report indicating that disability payments are due.

9.6. Reserve Analysis. IHI agrees to complete a reserve analysis worksheet for each Indemnity Claim when initially reported. Full reviews may also be performed whenever additional material information is received by IHI. IHI's current policy is to reserve sufficient sums to cover all probable expenditures and in accordance with Self-Insured Plans Guidelines with respect to a Claim.

9.7. Investigation. IHI agrees that all compensability investigations will be performed and completed within ninety days of IHI's knowledge of the questionable Claim.

9.8. Permits/Licenses. IHI agrees to obtain and maintain all material permits and licenses as required by law for the performance of the Services.

9.9. Contact. IHI shall endeavor to complete three-point contacts (physician, employer, and employee) by telephone or mail within two business days of receipt of a Claim.

10. Insurance. IHI shall maintain the following minimum insurance coverages during the term of this Agreement:

10.1. Workers' compensation at the statutory minimums;

10.2. Comprehensive general liability with a minimum of $2,000,000 combined single limit per occurrence and an aggregate limit of $4,000,000;

10.3. Professional liability/errors and omissions insurance with limits of $2,000,000 per claim; and

10.4. Comprehensive liability umbrella providing $2,000,000 coverage excess of primary.

10.5. **Crime Insurance (**Fidelity Bond**)** covering IHI's officers, employees, and volunteers with a minimum limit of **$2,000,000**.

10.6. Cyber/Network Privacy Insurance with a minimum limit of $2,000,000 per claim.

11. Waiver of Requirement to Exhaust Court Remedies. Client hereby expressly waives application of the doctrines of exhaustion of remedies, abstention, or comity and all other rights that might otherwise require that claims against Client, to the extent related to or arising hereunder, be heard in any court or other forum.

12. Agreement to Arbitration. The parties hereto agree that any dispute or claim that is directly or indirectly related to the Agreement, whether arising as a matter of tort, contract or otherwise, shall be resolved by binding arbitration under the commercial arbitration rules of the American Arbitration Association ("**AAA**"). An arbitration proceeding may be commenced only upon the filing with the AAA of a Statement of Claim (within the meaning of the AAA rules) and serving a copy thereof on the other party. The hearing on the arbitration shall be held in California and commence and be completed no more than thirty days after the close of discovery, and the arbitrator shall render an award in writing within thirty days of the completion of the hearing, which shall contain findings of facts and conclusions of law. Any arbitrator appointed hereunder may award interim injunctive relief before the final arbitration award. Any controversy concerning whether an issue is arbitrable shall be determined by the arbitrator.

13. Consent to Federal Bankruptcy Jurisdiction. In the event that either party is not Solvent, such party agrees to and does hereby voluntarily and irrevocably submit itself to the subject matter jurisdiction,

personal jurisdiction and service of process of the federal bankruptcy laws of the United States of America, as well as to the United States Bankruptcy Court of the Sacramento District of California.

14. General Provisions.

14.1. Notices. All notices that may be or are required to be given under this Agreement shall be sent to the respective parties at the address set forth below. Either party may change the places to which such notices are to be sent from time to time by a written notice as herein provided:

Intercare Holdings Insurance Services, Inc.
6020 West Oaks, Suite 100
Rocklin, CA 95675
Attn: Chief Executive Officer

Small Cities Organized Risk Effort (SCORE)
C/O Alliant Insurance Services
Attention: Program Director
2180 Harvard Street
Sacramento, CA 95815

14.2. Force Majeure. Except for payment obligations hereunder, no party shall be liable for failure to perform any of its obligations under this Agreement to the extent that such breach is caused by circumstances beyond such party's reasonable control, including, without limitation, acts of God, civil disturbances, natural disasters, or actions or decrees of governmental bodies. Upon the occurrence of any such event, the affected party immediately shall give notice to the other party and shall use reasonable commercial efforts to resume performance.

14.3. Severability. The invalidity in whole or in part of any provision hereof shall not affect the validity of any other provision. The provisions of this Agreement are severable and if any one or more such provisions shall be determined to be invalid, illegal or unenforceable, in whole or in part, the validity, legality and enforceability of any of the remaining provisions or portions thereof shall not in any way be affected or impaired thereby and shall nevertheless be binding between the parties hereto. Any such invalid, illegal or unenforceable provision or portion thereof shall be changed and interpreted so as to best accomplish the objectives of such provision or portion thereof within the limits of applicable law or applicable court decisions.

14.4. Waiver. A waiver of a breach of any term of this Agreement must be in writing and shall not be construed as a waiver of any succeeding breach of that term or as a waiver of the term itself. A party's performance after another's breach shall not be construed as a waiver of that breach. No failure or delay by a party to enforce or take advantage of any provision or right under this Agreement shall constitute a subsequent waiver of that provision or right, nor shall it be a waiver of any of the other terms and conditions of this Agreement.

14.5. Assignment. Neither party shall assign this Agreement or any rights hereunder, by law nor otherwise, without the other party's prior written consent; In the case of any permitted assignment or transfer of or under this Agreement, this Agreement or relevant provisions shall be binding upon, and

inure to the benefit of, the successors, representatives, administrators and assigns of the parties hereto. All purported assignment or transfers in violation of this Section shall be null and void.

14.6. Non-Solicitation. After contract termination or cancellation of the Agreement for any reason, each party agrees to not solicit or hire any of the other party's employees for a period of twelve months post termination.

14.7. Headings. Headings used in this Agreement are for reference purposes only and in no way define, limit, construe or describe the scope or extent of such section or in any way affect this Agreement.

14.8. Records. Subject to section 7b(iii) herein, the parties hereto shall maintain adequate records relating to the business contemplated hereunder in accordance with their respective customary practices and applicable law. Such records shall be maintained for a period of at least three years. Each party hereto, their authorized representatives and appropriate federal and regulatory agencies will have the right, at all reasonable times and to the extent permitted by law, to inspect and duplicate all such records; provided, however, that such examinations shall be carried out in a manner that reasonably protects the confidentiality of individual medical information. The obligation to maintain such records and provide such information shall not terminate upon the termination of this Agreement. IHI agrees that it will not use the records of Client's policy holders in the marketing of any form of insurance coverage without Client's prior written consent.

14.9. Governing Law and Consent to Jurisdiction. The parties hereto agree that this Agreement shall be interpreted and construed in accordance with the laws of the State of California, and that the substantive law to be applied in any arbitration shall be the substantive law of said state, each without regard to conflict of laws principles. The parties further agree to and do hereby voluntarily submit themselves to the subject matter jurisdiction, personal jurisdiction, service of process, and venue of the AAA arbitration, as well as to the Superior Court Sacramento, CA for the sole purpose of compelling arbitration or enforcing any arbitration award.

14.10. Independent Contractors. The parties to this Agreement are independent contractors, and no agency, partnership, joint venture or employee-employer relationship is intended or created by this Agreement. No party has the authority to contract for or bind the others in any manner whatsoever. This Agreement confers no rights upon a party except those rights expressly granted herein.

14.11. Entire Agreement. This Agreement sets forth the entire understanding and agreement of the parties and any and all previous agreements or understandings, whether oral or written, that are inconsistent with or additional to any of the various terms and conditions herein set forth are hereby canceled and rendered null and void. No agreement or understanding to modify this Agreement shall be binding upon a party unless agreed to in writing by an officer of each party authorized to bind such party.

14.12. Counterparts. This Agreement may be executed in counterparts with the same force and effect as if each of the signatories had executed the same instrument. If the Agreement is executed in counterparts, no signatory hereto shall be bound until both parties named below have duly executed or caused to be executed a counterpart of the Agreement.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed on the day and date first above written.

Small Cities Organized Risk Effort (SCORE)

By _____
Wes Heathcok
President

Date _____

Intercare Holdings Insurance Services, Inc.

By _____
Agnes Hoeberling
Chief Executive Officer

Date _____

SCORE
Exhibit A – Fee Schedule

CLAIMS ADMINISTRATION FEE (Fixed Per Year)[a]

Base Contract		**Fixed Flat Fee**
Year 1: 7/1/2023-6/30/2024	**$**	**108,495.60**
Year 2: 7/1/2024-6/30/2025	**$**	**111,750.47**
Year 3: 7/1/2025-6/30/2026	**$**	**115,102.98**
Option Years:		
Year 4: 7/1/2026-6/30/2027	**$**	**118,556.07**
Year 5: 7/1/2027-6/30/2028	**$**	**122,112.75**
Year 6: 7/1/2028-6/30/2029	**$**	**125,776.14**

[a] The fixed fee is for an average caseload not to exceed 125 IN claims per adjuster and a not to exceed claim volume of 40 new claims reported per year and takeover claims not to exceed 60 pending claims at the time of transfer. If the claim volume exceeds these numbers by 10% or more, Intercare reserves the right to adjust the fees if the change in claim volume results in additional staffing.

ALL OTHER SERVICES[bd]

All Other Services	**Rates**
Subrogation fees	20% of recovery
Bill Review	$10.00 per bill
PPO Access Fee	25% of savings
Specialty Review[e]	25% of savings
MPN Access (Standard MPN)	$5.00 per bill
Utilization Review, including if a fee applies for pass-through.	
a. Level 1 – Non-clinician	$25.00 per review
b. Level 2 – Clinical Nurse	$145.00 per review
c. Level 3 – Peer Review	$250.00 per hour
Medical network access fees	25% of savings
Case Management Fees[f]:	
a. Telephonic	$95.00 per hour
b. Field	$110.00 per hour plus travel
Pharmacy program fees	No BR fee for in-network prescription bills. BR fee will be charged for out of network bills.
Investigation fees:	
a. AOC/COE face to face	$85.00 per hour plus travel
b. Activity check and sub-rosa	$85.00 per hour plus travel
c. Background Investigation	$275.00 per case assignment
d. Social Media Investigation	$350.00 per assignment

e. SIU Services[c] **FD1 Filing** **Full Fraud Filing for Prosecution**	 $150.00 per report $500.00 per fraud package delivered to DOI
Claims Index Bureau fees	No charge using PRISM code
Client access fees	
a. Startup	No charge
b. Special report	No charge
c. Data transfer	$ 7,500.00 one-time fee payable in year 1
d. Data storage/maintenance	No charge
e. Monthly reports	No charge
f. OSHA reporting	No charge
g. Acknowledgments	No charge
h. System access	Access for 2 users included in Claims administration fee. Additional access available for $1,250 per user license per year

[b] A 3% Escalation rate is applicable annually to all other services.

[c] SIU fees are applicable only as services are rendered – requires prior client authorization

[d] If SCORE prefers to outsource any major components of the managed care program such as Bill Review, Utilization Review, Pharmacy Benefit Management, Ancillary Services, or Case Management, Intercare will charge a fee for programming the data interface between Intercare's claim system and the vendor's system, and a monthly maintenance fee to maintain the interface. In addition, the claims administration shall be adjusted by 20%.

Development and programming Fee: Standard or Simple Lay-out: per Interface	 $1,500.00 one-time fee
Custom/Complex Lay out: (In excess of 10 hours of development/programming) per Interface	 $500.00 one-time fee
Monthly maintenance fee per interface:	$100.00 per month per

[e] The Complex Bill Review is another opportunity to increase savings. This is usually for bills outside of the PPO network or bills that are not subject to OMFS and should further be negotiated. The negotiation is conducted by a nurse and can be done prospectively or retrospectively.

[f] Hourly rates are billed in 15-minute increments.