

Exhibit A

County of Monterey WC Claims Administration Fees

I. **Claims Administration – Fixed Annual Fee**

	Expiring Contract	Year 1 7/1/26-6/30/27	Year 2 7/1/27-6/30/28	Year 3 7/1/29-6/30/29
<i>Claims Administration</i>	\$ 1,370,315.58	\$ 1,451,591.41	\$ 1,502,397.11	\$ 1,554,981.01
<i>Monthly Fee</i>	\$ 114,192.965	\$ 120,965.95	\$ 125,199.76	\$ 129,581.75
<i>Percent Change</i>	3.6%	5.9%	3.5%	3.5%
Staffing Model:				
<i>Supervisor</i>	1.00	1.00	1.00	1.00
<i>Claims Adjuster III</i>	4.00	4.00	4.00	4.00
<i>Claims Adjuster -FM/MO</i>		1.00	1.00	1.00
<i>Claims Adjuster MO/FM</i>	1.00	.50	.50	.50
<i>Claims Assistants</i>	2.00	2.00	2.00	2.00
<i>Admin Support</i>	1.00	1.00	1.00	1.00
Total FTE	9.00	9.50	9.50	9.50

a. **Claim Volume Assumption:**

<i>Claim Type</i>	<i>New Claims</i>	<i>Pending Claims</i>
<i>First Aid/Incident Only</i>	12	1.0
<i>Medical Only</i>	125	10.4
<i>Indemnity</i>	0	0.0
<i>Total</i>	215	17.9

b. **Average Caseload:**

The average caseload used in determining the staffing model is 135 Indemnity claims per Adjuster and assumes Medical Only and Future Medical Claims were given half the weight of 1 Indemnity claim or 2:1 ratio.

c. **Economic and Market Considerations**

The proposed fees reflect economic conditions in our industry, including but not limited to increases in medical benefit costs and labor market pressures. Intercare adjusted its internal compensation range during the preceding contract year to maintain competitive positioning and ensure the recruitment, retention, and continued availability of qualified adjusting personnel. We anticipate ongoing

adjustments in the next couple of years. An increase of 5.9% in year 1 reflects the adjustments due to wage pressure to ensure staff retention.

d. Staffing Model:

Although the claim volume supports 1 dedicated plus a partial Supervisor, it is the County’s desire to maintain a dedicated Supervisor only. To ensure Intercare can properly deliver all required services, we have added one half of an Adjuster to the program model.

e. Adjustment for Claim Volume Changes

In the event the annual claim volume increases or decreases by more than ten percent (10%), and such variance necessitates an upward or downward adjustment in staffing levels, the Parties agree to negotiate in good faith an equitable adjustment to the fees. Any such modification shall be documented through a written amendment executed by both Parties.

II. Managed Care Services:

Services:	7/1/26-6/30/27	7/1/27-6/30/28	7/1/29-6/30/29
• Bill Review Services Flat fee per bill inclusive of PPO Access Fee	\$20.50 per bill	\$21.00 per bill	\$21.50 per bill
Complex Bill review – for out of network bills and bills that are not subject to fee schedule.	20% of savings	20% of savings	20% of savings
• Utilization Review			
Level 1 – Adjuster	\$15.00	\$15.00	\$15.00
Level 2 – Nurse	\$110.00 per hour	\$110.00 per hour	\$110.00 per hour
Level 3 – Medical Advisor	\$285.00 per hour	\$285.00 per hour	\$285.00 per hour
Peer Review	\$325.00 per hour	\$325.00 per hour	\$325.00 per hour
Specialty Peer Review	\$325.00 per hour	\$325.00 per hour	\$325.00 per hour
• Telephonic Case Management	\$115.00 per hour	\$115.00 per hour	\$115.00 per hour
• Nurse Triage – optional service	\$100.00 per call	\$100.00 per call	\$100.00 per call
• Telemedicine	OMFS	OMFS	OMFS
• Early Intervention Program (optional service)			
First 30 Days per claim	\$450.00	\$450.00	\$450.00
Month 2 per claim	\$375.00	\$375.00	\$375.00
Month 3 per claim	\$300.00	\$300.00	\$300.00
• Medical Records Review – (optional service)	\$115.00 per hour	\$115.00 per hour	\$115.00 per hour

III. Ancillary Services

Services:	7/1/26-6/30/27	7/1/27-6/30/28	7/1/29-6/30/29
a. MMSEA Section 111	\$750.00 per year	\$750.00 per year	\$775.00 per year
b. MPN Website Maintenance	\$2,000.00 per year	\$2,000.00 per year	\$2,000.00 per year
c. SIU Services			

- Background Check or	\$450.00 per assignment		
Social Media Monitoring			
- FD1/FD2 Filing	\$150.00 per filing	\$150.00 per filing	\$150.00 / filing
- SIU Filing DA or DOI	\$500.00 per filing	\$525.00 per filing	\$550.00 per filing

If at any time during the Term of the Contract, regulatory or legislative changes are enacted or made which impact Intercare's business operations and add to Intercare's costs of providing the services hereunder, the parties shall confer and adjust the claims administration fees appropriately and accordingly.

Claims administration fee includes the following services:

All tail claims and newly reported indemnity, medical only, first aid and incident only claims, standard monthly loss or adhoc reports, quarterly claim reviews, 1099's, SIP Annual Report, OSHA reports, periodic adjustment of Special Account Instructions, Claim Kits and posting notices, ISO Index, Customization of reports including stewardship reports and BOD reports, Check Printing, Banking Fees for trust accounts managed by Intercare, Utilization review approval at the adjuster level when allowed by statute, WCIS, FROI/SROI EDI reporting, Training. The dedicated unit is based on an average caseload not to exceed 135 per Indemnity adjuster with 2 FM/MO claims equivalent to 1 IN claim.

Claims administration fees is contingent upon Intercare providing all managed care services. The fees for such services shall be treated as allocated loss adjustment expenses and shall be charged at the rates outlined under the managed care section of the fee schedule above. Other ancillary services such as DME, Home Health, Transportation and Translation shall be provided by InterMed Cost Containment Solutions and billed to the claim file at or below OMFS.

Pharmacy Benefit Management Program shall be through Intercare's preferred vendor. The current preferred vendor is Optum. The Program fees shall be charged on all in-network prescriptions and not subject to a BR fee. Out-of-network prescriptions shall be subject to the Bill Review Fees set forth above.

IV. Workers' Compensation Performance Incentive Program:

- Purpose - The purpose of this Incentive Program is to promote strong program performance and support retention of claims professionals assigned to the County of Monterey Workers' Compensation Program.
- Eligibility - To be eligible for an incentive award, employees must:
 - a. Be assigned to the County of Monterey program for at least six (6) months; and
 - b. Be actively employed by Intercare at the time of bonus distribution; and
 - c. Remain in good standing, with no active disciplinary actions.
- Program Term - This plan is effective July 1, 2026, and aligns with the Contract's fiscal year. Participants must be continuously employed for the full 12-month measurement period and remain employed through the award determination and payment date.
- Performance Metrics - Incentive awards are based on the achievement of defined performance goals during the measurement period. The Parties may revise performance objectives annually, provided changes are agreed upon within 30 days following the prior fiscal year.

I. Closing Ratio Incentive

- Objective - Increase claim closure rates to meet or exceed performance targets.
- Conditions – Total Team Bonus Pool capped at \$10,000 annually. The maximum adjuster bonus shall be \$1,500.00. The County must provide timely settlement authority; results depend on funding availability for Compromise & Release (C&R) settlements.

Job Title	Closing Objective	Incentive Amount
Claims Adjuster	100% to 110%	\$1,000.00
Claims Adjuster	Over 110%	\$1,500.00
Claims Supervisor	Overall Team result 110% or better	\$1,750.00

II. **PRISM Audit Incentive**

- Objective - meet or exceed PRISM audit standards during the biennial audit.
- Conditions:
 - Applies to the PRISM audit conducted every two years.
 - Maximum total incentive pool: \$10,000.
- Incentive Structure

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a.

Role	Incentive
Claims Adjuster	\$1,000.00
Claims Supervisor	\$1,200.00

b.

Exhibit A – Scope of Work – Workers’ Compensation

I. Claims Administration Services.

- a. Upon receipt of claim form from Client, electronically file reports of injury to the appropriate jurisdiction, if not already filed by Client.
- b. Review each Claim received from Client and process such Claim in accordance with the Client’s Insurance Program and in accordance with reasonable Workers’ Compensation administrative practices and accepted industry standards, and pursuant to any specific service instructions agreed upon with Client.
- c. Investigate 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 Intercare’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.
- d. Make compensability determination and issue appropriate determination notices.
- e. Arrange for and retain independent investigators or medical or other experts, to the extent deemed necessary or desirable by Intercare, in connection with processing any Claim.
- f. 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 a regular and periodic basis.
- g. Make prompt payment of all benefits including medical and death benefits, temporary and permanent disability compensation and other losses and expenses on Qualified Claims (a) if, in the judgment of Intercare, 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.
- h. 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.
- i. Assist in connection with Client’s selection of defense counsel to defend Qualified Claims or losses, if requested by Client.
- j. Assist Client’s selected defense counsel in preparing the defense of litigated Claims, negotiating settlements, and pursuing subrogation or contribution actions.
- k. 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 Intercare; and (b) manage the medical treatment in accordance with Insurance Program.

- l. 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. Client may designate Intercare as an RRE Agent to file on behalf of Client, the monthly eligibility query and Quarterly Reporting with the Center for Medicare and Medicaid Services.
- m. Provide initial claims forms packets as deemed appropriate by Intercare for efficient administration of Claims in compliance with the Insurance Program.
- n. Comply with Client's service instruction guidelines for the administration of the Services as such Services are set forth in this Agreement.
- o. Establish and maintain an electronic record file for each Claim.
- p. 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. If the frequency of new claims increases to a level that warrants the addition of staff to maintain the caseload requirements, Intercare 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. In calculating the average caseload, Medical Only and/or Future Medical claims shall be weighted as 50% of an Indemnity claim.

II. Administrative Services. Intercare shall:

- a. 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.
- b. Participate in the orientation of Client's personnel who are directly or indirectly involved in the processing of Claims.
- c. Provide information on changes or proposed changes in legislation, rules or regulations affecting the responsibility of Client with respect to Claims.
- d. Review the development of the Insurance Program periodically with representatives of Client to identify problems and recommend corrective action.
- e. Provide training sessions annually to the Client including Basic Workers' Compensation Guidelines and Fraud Detection.
- f. Meet periodically with Client at mutually agreeable times to review active claims on a quarterly basis to discuss claim management strategies.
- g. Provide Client with standard loss 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 Intercare to prepare such items; Client may specify from the list of available reports which reports will be sent to them on a regular basis.

- h. If 1099 forms are required to be issued in accordance with the benefit delivery system, arrange for issuance of 1099s at no additional cost to client.
- i. Deliver a standard annual stewardship report outlining program trends and outcomes.

III. Medical Control Services.

- a. 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.
- b. 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.
- c. Endeavor to utilize managed care services including Bill Review, Utilization Review and Case management as a form of cost containment when warranted using Intercare's Managed Care Division, InterMed Cost Containment Services.

Exhibit A
County of Monterey
Liability Program Fees

I. Liability Claims Administration Fees:

Contract Year	Rate
7/1/26-6/30/27	\$ 175,000.00
7/1/27-6/30/28	\$ 182,000.00
7/1/28-6/30/29	\$ 189,000.00

Assumptions:

- a. The average caseload per adjuster shall not exceed 150 claims.
- b. Rates are subject to a 4% increase at the contract anniversary date.
- c. Claims administration fees include the following services:
 - RMIS reports: ad hoc reporting and unlimited standard bordereaux of reports; custom development of reports up to 4 hours.
 - Quarterly claim review (2 virtual and 2 in person)
 - ISO Claim search for up to 100 claims per year.
 - Online Claim Intake.
- d. Development/programming time in excess of 4 hours shall be billed at the rate of \$175.00 per hour – subject to SOW approval by the client.
- e. The program will move under the supervision of Chris Shaffer under the AL/GL Operating Division. Tasso Mouvradis will remain as the Claims Manager on the program.

II. Administrative Services:

Service Description:	Rates
a. MMSEA Section 111 Reporting (monthly query/quarterly reporting)	\$1,000.00 per year
b. SIU Services:	
▪ Background Investigation (per assignment)	\$450.00
▪ Preparation and submission Fraud Report (full package)	\$750.00 per case
g. First Party Subrogation Recovery	20% of recovery
▪ George Hills Subrogation Recovery Unit shall handle recovery opportunities at the request of the County.	

III. Liability Performance Incentive For Adjuster:

PRISM Audit Meets or Exceeds Bonus Incentive (Every Two-Year audit):

1. Bonus Incentive:

1. The program achieves an overall meet or exceeds PRISM audit standards (Potential Every Two-Year Highest Bonus Potential Combined) \$5000.00:
 1. COM staff who are employed and part of the COM program during the audit period and by the final report of the audit wrap-up are eligible for a performance incentive of:

1. \$5,000.00 per Claims Manager/Adjuster (1 FTE)

Client may have the option to renew in successive 12 months period. A 4% or CPI escalation rate for each renewable period shall be applied to the expiring rate.

Program Pricing For Claims Administration - Sweetgreen

a) Allocated Expenses (ALAE) are excluded from any claim or managed care fees. ALAE's are those expenses that are generated by a claim (by outside vendors other than Intercare) that cannot be foreseen nor included in this Contract. These expenses 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 these 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 outsource services to a third-party consultant and/or miscellaneous fees applicable to the specific claim applied by an outside entity, such as:

- 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
- Costs of undercover operatives and detectives (if initially paid by GH)
- 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 judgement 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 are 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 TPAs normal geographical regions
- Costs associated with Medicare Set-Aside analysis and submission of Medicare Conditional Lien negotiation
- Investigation of possible fraud including SIU services and related expenses
- Extraordinary cost of travel related to claims including mileage drive, such as for attendance at inspections, mediations, and trial, shall be allocated to the specific claim and reimbursed to GH based on the actual cost incurred. Mileage shall be reimbursed at the current IRS rated at the time the mileage is traveled.

SCOPE OF WORK - Liability

CONTRACTOR shall provide services and staff, and otherwise do all things necessary for or incidental to the performance of work, as set forth below:

A1. Resource

Staffing Level:

- Designated Senior Claims Specialist with expertise in managing liability claims for public entity
- Designated Claims Supervisor with public entity experience
- Designated Back-Up – Senior Claims Specialist with expertise in AL/GL

Other Resources:

- In-house IT Department including 24/7 Helpdesk
- Accounting Department/Trust account administration
- Centralized Check processing system
- Online Claim Intake System accessible 24/7
- Quality Assurance and Compliance Review
- RMIS System with robust reporting technology
- Business Analyst
- Client Success Manager

Subcontracted Services at County Approved Rates

- Auto/vehicle damage appraisals
- Property damage appraisals
 - Intercare will use County of Monterey preferred vendor or recommend a vendor from Intercare panel.
- Investigation Services: Outside investigator/field adjuster services are "pass through," as claims allocated costs are incurred.
- Medical Bill Repricing/Negotiation – Medical bill review fees are to be separately accounted for and direct billed to claim file as an allocated loss adjustment expense (ALAE) with supporting documentation of review and savings. Bill review fee shall be subject to the same rate as the WC Bill Review rates.

A2. Services

Process	Details
Intake	Losses reported via online system or email/fax/phone.. Acknowledgement of report along with handling specialist name and contact information is sent upon receipt of report.
Set-Up	Set-up file within 24 hours; appropriate codes entered and claim number assigned.
Contact	Within 24 hours: <ol style="list-style-type: none"> 1. Claimant 2. Witnesses 3. County Department 4. County Risk Management
Investigation Findings	Ongoing communication on the onset of the claim with the goal of completing the investigation within 30 days. Analyze coverage and communicate determination to the County before sending the acceptance or rejection.
Reserves	Each claim should be reviewed and evaluated according to the merits of the claim based upon the most current and reliable information received, starting with the initial report of claim and continuing through final resolution.
Claim Notes	Claim notes, diaries, action plans entered in Claims Enterprise.
County Access to Electronic Claim Information	Access to all data including reserves, diaries, notes, action plans, payments, imaged documents/correspondence, legal/medical information, any data captured in the system.
Compliance with Government Code 910	Review government claim form within 7 days and provide oral and written recommendations.
Litigation Management	Will work collaboratively with County Risk Management, County Counsel or designated counsel every step of the way – maintain ongoing communication, attend mediation, seek approval when

	retaining defense counsel, settlement evaluation, disposition and all legal proceedings.
CMIS System	Riskconnect Claims Enterprise System with a Medicare Module to comply with MMSEA Section 111 reporting.
Standard Reports	Frequency and Severity Reports, Top 10 Causes, Top 10 Risks, Reserve Trends, Loss Summary, Loss Stratification Report, Reserve Development Reports, Excess Claim Reports, Subrogation Reports, Litigated Claim Reports, Check Register, Payment Report.
Internal Controls	SSAE 16 and SOC 2 annually; Business Continuity Plan, Disaster Recovery Plan; Secured email.
Other Services	Account Management/Client Services, Annual Stewardship Review, Quarterly Roundtable Claim Review, Topical Captioned Status Report, Claim Analysis, Excess Reporting, MMSEA Reporting, Training.

All written reports required under this Agreement must be delivered to Risk Manager, in accordance with the schedule above.

B. Public Risk Innovations Solutions, and Management (PRISM) - Excess Insurance Requirements

Contractor shall comply with all reporting requirements of the Public Risk Innovations, Solutions, and Management (PRISM). Requirements include:

Providing timely notice to Risk Management and PRISM of any claim that may exceed the County's self-insured retention. Submit the first report notice to PRISM electronically. A copy of the first report and all follow-up reports submitted to PRISM shall be provided to Risk Management.

- Contractor shall communicate with PRISM and the County in accordance with PRISM's policies, including but not limited to sending PRISM, weekly, monthly, quarterly and/or yearly statistical reports.
- Contractor shall notify the County if it believes any claim it is handling on behalf of the County would fall outside of the coverage provided under PRISM Memorandum of Coverage.
- Compliance with Addendum B.