

**Request for Proposal
RFP #2897**



**Workers Compensation Third Party
Administrator Services**

EXHIBIT A & B

See following page for exhibits.

State of California



Public Self Insurers ER Annual Report

For Fiscal Year 2024-25

September 12, 2025
County of Marin
3501 Civic Center Dr
San Rafael, CA 94903 4112

FORM AR-2 (1-2016)

State of California

Employer

General Information:

Certificate Number	7017	Period Of Report	Annual
(Period) From	07/01/2024	(Period) To	06/30/2025

Master Certificate Holder:

Name	County of Marin		
Address 1	3501 Civic Center Dr		
Address 2		FTIN	94-6000519
City	San Rafael	State	CA Zip 94903 4112
State of Incorporation			

State of California

During the reporting period of this report, has there been any of the following with respect to the Master Certificate Holder for any affiliate?

None

Any additions to the Self Insurance Program?

None

Employment and wages paid in current fiscal year:

Number of Employees 2,832

Total Wages and Salaries Paid \$262,498,638

Addressed Correspondence For Related Self-Insurance Matters:

Company Name	County of Marin		
Name	Reesha Ruel	Title	Risk Manager
Phone	(415) 473-6445	Fax	(415) 499-3729
Email Address	reesha.ruel@marincounty.gov		
Address 1	3501 Civic Center Drive Rm. 421		
Address 2			
City	San Rafael	State	CA Zip 94903
Web Site			

State of California

TPA Adjusting Locations:

Has there been a change in TPA Adjusting Locations during this reporting period that has not yet been reported to OSIP? No

Have you added any new TPA Adjusting Locations during this reporting period that has not yet been reported to OSIP? No

Record Storage:

Are there open and closed claims stored at a location other than the adjusting location? No

Insurance Coverage:

1) During this reporting period, does your company maintain a standard workers' compensation insurance policy to cover any of your California liabilities? Yes

	Insurance Company Name	Policy Number	Policy Issue Date
1)	Arch	WCX 0033430 16	07/01/2024
	Retention Limit \$1M SIR		

2) During this reporting period, does your company have a specific excess workers' compensation policy in force to cover any of your California liabilities? No

3) Do you carry an aggregate(stop loss) workers' compensation insurance policy? No

State of California

Certification By Authorized Representative:

Company Name County of Marin

Name Reesha Ruel

Title Risk Manager

Phone (415) 473-6445

Fax (415) 499-3729

Email Address reesha.ruel@marincounty.gov

Address 1 3501 Civic Center Drive Rm. 421

Address 2

City San Rafael

State CA **Zip** 94903

Name of Person Legally Responsible for this Electronic Signature:

Reesha Ruel (Date/Time of Signature) - 09/12/2025 14:38

State of California

Report Location Number: 7017-01-048 A **Identification of Location:** ATHENS ADMINISTRATORS at CONCORD **Certificate Holder:** County of Marin

CASES AND BENEFITS (to the nearest dollar)				From Date-	07/01/2024	To Date-	06/30/2025
Date	#	Incurred Liability		Paid To Date		Future Liability	
		Indemnity	Medical	Indemnity	Medical	Indemnity	Medical
1) Cases open as of 06/30/2025 reported prior to 2020/21	109	\$13,637,388	\$18,473,761	\$8,968,855	\$9,272,745	\$4,668,533	\$9,201,016
2) Open and closed Liabilities							
A) All Cases reported in 2020/21	214	\$1,777,176	\$1,990,681	\$1,476,386	\$790,496	\$300,790	\$1,200,185
2020/21 Cases open	19	\$1,021,486	\$1,562,105	\$720,696	\$361,920	\$300,790	\$1,200,185
B) All Cases reported in 2021/22	233	\$3,845,068	\$2,637,832	\$2,803,153	\$1,193,187	\$1,041,915	\$1,444,645
2021/22 Cases open	39	\$3,469,931	\$2,323,452	\$2,428,016	\$878,807	\$1,041,915	\$1,444,645
C) All Cases reported in 2022/23	157	\$2,125,178	\$1,774,002	\$1,431,185	\$773,838	\$693,993	\$1,000,164
2022/23 Cases open	30	\$1,828,710	\$1,510,117	\$1,134,717	\$509,953	\$693,993	\$1,000,164
D) All Cases reported in 2023/24	167	\$1,063,169	\$701,567	\$583,084	\$335,715	\$480,085	\$365,852
2023/24 Cases open	18	\$930,871	\$529,086	\$450,786	\$163,234	\$480,085	\$365,852
E) All Cases reported in 2024/25	174	\$1,324,907	\$1,003,472	\$546,577	\$359,959	\$778,330	\$643,513
2024/25 Cases open	71	\$1,130,666	\$784,167	\$352,336	\$140,654	\$778,330	\$643,513

	\$ Indemnity	\$ Medical
SUBTOTAL	\$7,963,646	\$13,855,375
TOTAL		\$21,819,021
	\$ Indemnity	\$ Medical
	\$1,531,486	\$1,510,770

3) Estimate Future Liability (Indemnity Plus Medical)	
4) Total Benefits Paid During 2024/25 (Including all case expenditures). The indemnity amount includes the amount of LC § 4800/4850 benefits paid for the year (total of Lines 11 and 12)	
5) Number of MEDICAL-ONLY Cases Reported in 2024/25	63
6) Number of INDEMNITY Cases Reported in 2024/25	111
7) Total of 5 and 6 (Also entered in 2E above)	174
8) Total Number of open Indemnity Cases (All Years)	264
9) Number of Fatality Cases Reported In 2024/25	0
10) (a) Number of FY 2024/25 claims for which the employer or administrator was notified of representation by an attorney or legal representative in 2024/25	8
10) (a) Number of non-FY 2024/25 claims for which the employer or administrator was notified of representation by an attorney or legal representative in 2024/25	9
11) Amount from salary continuation payments made pursuant to LC § 4800/4850 that is in excess of the applicable temporary disability rate for the period paid.	\$329,424
12) Amount from salary continuation payments made pursuant to LC § 4800/4850 capped at the temporary disability rate for the period paid.	\$468,131

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ALL Open Indemnity Claims (by reporting and by year) reported and with claims: Open Indemnity - Public.xlsx

State of California

Dual Jurisdiction Claims

Please note that California Labor Code Section 3702.2(b) requires that "... the annual report of a self-insured employer who has self-insured both state and federal workers' compensation liability shall also be set forth (1) amount of all compensation liability incurred, paid-to-date, the estimated future liability under both this chapter and under the federal longshore and Harbor Worker's Compensation Act (33 U.S.C Sec. 901 et seq.), and (2) the identity and the amount of the security deposit securing the employer's liability under state and federal self-insured programs."

Accordingly, please indicate all California exposure on your Self Insurer's Annual Report, and, in addition identify each Claim with dual jurisdiction on Separate List of Open Idemnity Claims. For those claims, indicate the incurred, paid-to-date, and estimated future liabilities for federal exposure. Please also indicate the amount and the type of security deposit securing those claims.

Instructions To Claims Administrator For Specific Excess Insurance

The TPA should provide a sum of the unpaid excess carrier excess liability under "Calculation of Specific Excess Coverage Entry for the Annual Reports". In addition, provide a list of claims for which specific excess credit is being claimed. This may be provided as a spreadsheet. Indicate in the list of claims the following information:

The list shall include the name of the claimant, claim number, date of injury, description of injury, carrier name and policy number, policy coverage period, retention level of policy and paid to date in indemnity or medical benefits, and the estimated future liability of the claim minus the total unpaid employer retention, which equals the total unpaid carrier liability, whether the claim has been reported to a carrier, if the claim has been accepted by the carrier, if the carrier has denied any part of the liability of the claim.

Refer to OSIP website for sample format of the Excess Credit Calculation form.

Calculation Of Specific Excess Coverage Entry For Annual Reports:

Enter the sum of the total unpaid carrier excess liability claimed from the "Specific Excess Insurance Policy Coverage". If none enter "0". \$

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Certification

Administrating Agency's Certificate Number 048

Or Self Administered

I declare under penalty of perjury that I have prepared or caused this report to be prepared and I have examined this liabilities report to be prepared and I have examined this liabilities report of this self insurer's worker's compensation liabilities. To the best of my knowledge and belief this report is true, correct and complete with respect to the worker's compensation liabilities incurred and paid. I further declare under the penalty of perjury that the estimates of future liability of worker's compensation claims made in this report reflect the administrator's best judgement as to the future liability of claims, using prevailing industry standards, and the signatory intends Self Insurance Plans to rely upon the representation.

Agency Name ATHENS ADMINISTRATORS
Name Douglas Gibb
Phone (925) 826-1283 **Fax**
Email Address dgibb@athensadmin.com
Address 1 2552 Stanwell Dr.
Address 2
City Concord **State** CA **Zip** 94520

Name of Person Legally Responsible for this Electronic Signature:

Emily Hart (Date/Time of Signature) - 07/21/2025 14:55

EXHIBIT B



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

ADDENDUM A WORKERS' COMPENSATION CLAIMS ADMINISTRATION STANDARDS

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

I. CLAIMS HANDLING - ADMINISTRATIVE

A. Case Load

1. Each claims examiner assigned to the Member should handle a targeted caseload of 150 but not to exceed 165 claims. In situations where caseloads include future medical and medical only claims, these claims shall be counted as 2:1 in the caseload limit.
2. Supervisory personnel should not handle a caseload, although they may handle specific issues or a small number of conflict claims.

B. Case Review and Documentation

1. Documentation shall reflect any significant developments in the file and include a plan of action. Plan of action statements shall be updated at the time of examiner diary review.
2. The examiner shall review indemnity and medical-only files at intervals not to exceed 45 calendar days. Future medical files shall be reviewed at intervals not to exceed 90 calendar days.
3. The supervisor shall review all new claims within 60 calendar days of initial set up and subsequently monitor activity on indemnity files at intervals not to exceed 120 calendar days. Future medical files shall be reviewed by the supervisor at intervals not to exceed 180 calendar days.

4. File contents shall comply with Code of Regulations Sections 10101, 10101.1 and 15400, and be kept in a neat and orderly fashion. If claims are maintained in a paperless system, documents shall be clearly identified (e.g., medical report, WCAB Orders, legal, etc.).
5. Medical Only Claims
 - a. If a medical-only claim is still open at 90 calendar days, it shall be transferred to an indemnity examiner.
 - b. If, at any time, it is anticipated there will be indemnity benefits paid, the claim shall be transferred to an indemnity claim type.
 - c. If the medical-only claim remains open at 180 days, the claim shall be converted to an indemnity claim type, unless there is documentation showing that medical treatment will be ending and the claimant will be discharged from care within the next 30 days, or the claimant is only seeking treatment for a blood-borne pathogen exposure protocol.

C. Communication

1. Telephone Inquiries

Return calls shall be made within 1 working day of the original telephone inquiry. All documentation shall reflect these efforts.

2. Incoming Correspondence

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

3. Return Correspondence

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

4. Ongoing Claimant Contact

On cases involving unrepresented injured workers who are off work, telephone contact shall be made at a minimum of once every 30 days and within 3 working days after discharge from the hospital or outpatient facility following a surgical procedure. This is in addition to nurse case management involvement on claims where nurse case managers are assigned.

D. Fiscal Handling

1. Fiscal handling for indemnity benefits on active cases shall be balanced with appropriate file documentation on a semi-annual basis and prior to sending a benefit termination notice to verify that statutory benefits are paid appropriately. Balancing is defined as, "an accounting of the periods and amounts due in comparison with what was actually paid".
2. In cases of multiple losses with the same person, payments shall be made on the appropriate claim file.

E. Medicare Reporting

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

II. CLAIM CREATION

A. Three-Point Contact

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

B. Compensability

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

2. Delay of benefit letters shall be mailed in compliance with the Division of Workers' Compensation (DWC) guidelines. In the event the employer does not provide notice of lost time to the third party administrator or self-administered entity timely to comply with DWC guidelines, the third party administrator or self-administered entity shall mail the benefit letters within 7 calendar days of notification.
3. The final compensability determination shall be made by the claims examiner or supervisor within 90 calendar days of employer receipt of the claim form.

C. AOE/COE Investigation

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

D. Reserves

1. Using the information available at claim file set up, an initial reserve shall be established for the most probable case value.
2. The initial reserve shall be electronically posted to the claim within 14 calendar days of receipt of the claim.

E. Indexing

All claims shall be reported to the Index Bureau at time of initial set up and re-indexed on an as needed basis thereafter. Blood borne pathogen exposure claims are an exception to this requirement.

PRISM maintains membership with the Index Bureau that members can access.

III. CLAIM HANDLING – TECHNICAL

A. Payments

1. Initial Temporary and Permanent Disability Indemnity Payment
 - a. The initial indemnity payment shall be issued to the injured worker within 14 calendar days of knowledge of the injury and disability. In the event the third party administrator or self-administered entity is not notified of the injury and disability

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

- b. The properly completed DWC Benefit Notice shall be mailed to the employee within 14 calendar days of the first day of disability. In the event the third party administrator or self-administered entity is not notified of the first day of disability until after 14 calendar days, the DWC Benefit Notice shall be mailed within 7 calendar days of notification.
- c. Self-imposed penalty shall be paid on late payments in accordance with Section III. A.7 of this document.
- d. Overpayments shall be identified and reimbursed timely where appropriate. The third party administrator or self-administered entity shall request reimbursement of overpaid funds from the party that received the funds. If necessary, a credit shall be sought as part of any resolution of the claim.

2. Subsequent Temporary and Permanent Disability Payments

- a. Eligibility for indemnity payments subsequent to the first payment shall be verified, except for established long-term disability.
- b. Ongoing indemnity payments shall be paid in accordance with Labor Code Section 4650(c).
- c. Subsequent DWC benefit notices shall be issued in accordance with CCR 9812.
- d. Self-imposed penalty shall be paid on late payments in accordance with Section III. A.7 of this document.

3. Final Temporary and Permanent Disability Payments

- a. All final indemnity payments shall be issued timely.
- b. The appropriate DWC benefit notices shall be issued in accordance with CCR 9812.
- c. Self-imposed penalty shall be paid on late payments in accordance with Section III. A.7. of this document.

4. Award Payments

- a. The claim file shall reflect demonstrated efforts to initiate/batch payments on undisputed Awards, Commutations, or Compromise and Release agreements within 10 working days following receipt of the appropriate document, unless the Award indicates payment is due sooner.
- b. For all claims in the Primary Workers' Compensation (PWC) Program and/or excess reportable claims, copies of all Awards shall be provided to PRISM at time of payment.

5. Medical Payments

- a. Medical treatment billings (physician, pharmacy, hospital, physiotherapist, etc.) shall be reviewed for correctness, approved for payment and paid within 60 days of receipt.
- b. The medical provider shall be notified in writing within 30 days of receipt of an itemized bill if a medical bill is contested, denied or incomplete.
- c. A bill review process should be utilized whenever possible. There should be participation in a PPO and/or MPN whenever possible.

6. Injured Worker Reimbursement Expense

- a. Reimbursements to injured workers shall be issued within 15 working days of the receipt of the claim for reimbursement.
- b. Advance travel expense payments shall be issued to the injured worker 10 working days prior to the anticipated date of travel.

7. Penalties

- a. Penalties shall be coded so as to be identified as a penalty payment.
- b. If the Member utilizes a third party administrator, the Member shall be advised of the assessment of any penalty for delayed payment and the reason thereof, and the administrator's plans for payment of such penalty, on a monthly basis.
- c. If the Member utilizes a third party administrator, the Member, in their contract with the administrator, shall specify who is responsible for specific penalties.

B. Medical Treatment

1. Each Member shall have in place a Utilization Review process as set forth in Labor Code Section 4610.
2. Disputes regarding utilization review determinations shall be resolved using the Independent Medical Review process set forth in Labor Code Section 4610.5.
3. Nurse case managers shall be utilized where appropriate. Rationale for assignment and continued necessity shall be documented in the claim notes at each regular diary review.
4. If enrolled in a Medical Provider Network, the network shall be utilized whenever appropriate.

C. Apportionment

1. Investigation into the existence of apportionment shall be documented.
2. If potential apportionment is identified, all efforts to reduce exposure shall be pursued.

D. Disability Management

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

2. The third party administrator or self-administered entity shall notify a designated Member representative immediately upon receipt of an employee's permanent work restrictions so that the Member can determine the availability of alternative, modified or regular work.
3. If there is no response within 20 calendar days, the third party administrator or self-administered entity shall follow up with the designated Member representative.
4. Members shall have in place a process for complying with laws preventing disability discrimination, including Government Code Section 12926.1, which requires an interactive process with the injured worker when addressing a return to work particularly with permanent work restrictions.
5. Third party administrators or self-administered claims professional shall cooperate with members to the fullest extent, in providing medical and other information the member deems necessary for the member to meet its obligations under federal and state disability laws.

E. Supplemental Job Displacement Benefits

1. Supplemental Job Displacement Benefits – Dates of injury on or after 1/1/04 and before 1/1/13: Benefits pursuant to Labor Code Section 4658.5 shall be timely provided. Dates of injury on or after 1/1/13: Benefits pursuant to Labor Code 4658.7 shall be timely provided.
2. The third party administrator or self-administered entity shall secure the prompt conclusion of SJDB.

F. Reserving

1. Reserves shall be reviewed at regular diary and at time of any significant event, e.g. - surgery, P&S/MMI, return to work, etc., and adjusted accordingly. This review shall be documented in the file regardless of whether a reserve change was made. Where the SIP model does not apply, claims shall be reserved for the most probable value.
2. Indemnity reserves shall reflect actual temporary disability indemnity exposure with 4850 differential listed separately.
3. Permanent disability indemnity exposure shall include life pension reserve if appropriate.

4. Future medical claims shall be reserved in compliance with CCR 15300 (b)(4) allowing adjustment for reductions in the approved medical fee schedule, undisputed utilization review, medically documented non-recurring treatment costs and medically documented reductions in life expectancy.
5. Allocated expense reserves shall include medical cost containment, legal, investigation, copy service and other related fees.
6. A reserve worksheet shall be utilized and/or detailed rationale substantiating reserve levels shall be documented within the claim file.

G. Resolution of Claim

1. Within 10 working days of receiving medical information indicating that a claim can be finalized, the claims examiner shall begin appropriate action to finalize the claim.
2. Follow up finalization efforts shall continue and be documented at regular diary reviews until resolution is complete.
3. Settlement value shall be documented appropriately utilizing all relevant information.
4. Where settlement includes resolution of future medical for a Medicare beneficiary or an expected Medicare beneficiary, the settlement shall document the strategy to protect Medicare's secondary payer status.
5. Pursuant to CCR15400.2, claim files with awards for future benefits shall be reviewed for administrative closure two years after the last provision of benefits.

H. Settlement Authority

1. No agreement shall be authorized involving liability, or potential liability, of PRISM without the advance written consent of PRISM. The member shall be notified of any settlement request submitted to PRISM.
2. The third party administrator shall obtain the Member's authorization on all settlements or stipulations in excess of the settlement authority provided in any provision of the individual contract between the Member and the claims administrator.

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

IV. LITIGATED CASES

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

1. The third party administrator or self-administered entity shall promptly initiate investigation of issues identified as material to potential litigation. The Member shall be alerted to the need for in-house investigation, or the need for a contract investigator who is acceptable to the Member. The Member shall be kept informed on the scope and results of investigations.
2. The third party administrator or self-administered entity shall, in consultation with the Member, assign defense counsel from a list approved by the Member. Initial referral and ongoing litigation management shall be timely and appropriate. The third party administrator or self-administered entity shall maintain control of the ongoing claim activities.
3. Settlement proposals directed to the Member shall be forwarded by the third party administrator, self-administered entity or defense counsel in a concise and clear written form with a reasoned recommendation. Settlement proposals shall be presented to the Member as directed so as to insure receipt in sufficient time to process the proposal.
4. Knowledgeable Member personnel shall be involved in the preparation for medical examinations and trial, when appropriate or deemed necessary by the Member so that all material evidence and witnesses are utilized to obtain a favorable result for the defense.
5. The third party administrator or self-administered entity shall comply with any reporting requirement of the Member.

V. SUBROGATION

1. In all cases where a third party (other than a Member employee or agent) is responsible for the injury to the employee, attempts to obtain information regarding the identity of the responsible party shall be made within 14 calendar days of recognition of subrogation potential.

2. Once identified, the third party shall be contacted within 14 calendar days with notification of the Member's right to subrogation and the recovery of certain claim expenses.
3. If the third party is a governmental entity, a claim shall be filed with the governing board (or State Board of Control as to State entities) within 6 months of the injury or notice of the injury. If the third party is a non-governmental entity, a complaint shall be filed in civil court within two years in order to preserve the statute of limitations.
4. Periodic contact shall be made with the responsible party and/or insurer to provide notification of the amount of the estimated recovery to which the Member shall be entitled.
5. If the injured worker brings a civil action against the party responsible for the injury, the claims administrator shall consult with the Member about the value of the subrogation claim and other considerations. Upon Member authorization, subrogation counsel shall be assigned to file a Lien or a Complaint in Intervention in the civil action.
6. Whenever practical, the claims administrator shall aggressively pursue recovery in any subrogation claim. They should attempt to maximize the recovery for benefits paid, and assert a credit against the injured worker's net recovery for future benefit payments.
7. Member (and PRISM if applicable) approval is required to waive pursuit of subrogation or agree to a settlement of a third party recovery. This approval shall be documented in the claim file. In cases of self-administered entities, a process shall be documented noting the authority levels within the member organization to waive pursuit of subrogation or agree to a settlement of a third party recovery.

VI. EXCESS COVERAGE

- A. Claims meeting the definition of reportable excess workers' compensation claims as defined by the Memorandum of Coverage Conditions Section shall be reported to PRISM within five working days of the day on which it is known the criterion is met. Utilize the Excess Workers' Compensation First Report Form available through PRISM's website.
- B. Subsequent reports shall be transmitted to PRISM on a quarterly basis on all indemnity claims and on a semi-annual basis on all future medical claims or sooner if claim activity warrants, or at such other intervals as requested by PRISM, in accordance with Underwriting and Claims Administration Standards. Utilize the Excess Workers' Compensation Status Report Form

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

- C. Reimbursement requests shall be submitted in accordance with PRISM's reporting and reimbursement procedures on a quarterly or semi-annual basis depending on claims payment activity. Utilize the Excess Workers' Compensation Claim Reporting and Reimbursement Procedures available through PRISM's website.
- D. A closing report with a copy of any settlement documents not previously sent shall be sent to PRISM.

Following is the history of amendments to this document:

Amended: March 4, 1988
Amended: October 7, 1988
Amended: October 6, 1995
Amended: October 1, 1999
Amended: June 6, 2003
Amended: March 2, 2007
Amended: July 1, 2009
Amended: July 1, 2011
Amended: March 2, 2012
Amended: October 4, 2013
Amended: July 1, 2019