CITY OF RICHMOND
STANDARD CONTRACT

Department:	Project Manager:
Project Manager E-mail:	Project Manager Phone No:
PR No: Vendor No:	P.O./Contract No:
Description of Services:	

The parties to this STANDARD CONTRACT do mutually agree and promise as follows:

1. Parties. The parties to this Contract are the City of Richmond (herein referred to as the "City") and the following named Contractor:

   Company Name: _____

   Street Address: _____

   City, State, Zip Code: _____

   Contact Person: _____

   Telephone: _____ Email: _____

   Business License No: _____ / Expiration Date: _____

   A California [ ] corporation, [ ] limited liability corporation [ ] general partnership, [ ] limited partnership, [ ] individual, [ ] non-profit corporation, [ ] individual dba as [specify:] _____,
   [ ] other [specify:] _____

2. Term. The effective date of this Contract is _____ and it terminates _____ unless terminated as provided herein.

3. Payment Limit. City's total payments to Contractor under this Contract shall not exceed $_____. City shall not pay for services that exceed the Contract Payment Limit unless a contract amendment has been approved by the City Council or City Manager.

4. Contractor's Obligations. Contractor shall provide those services and carry out that work described in the Service Plan (Exhibit A) which is attached hereto and is incorporated herein by reference, subject to all the terms and conditions contained or incorporated herein.

5. City's Obligations. City shall make to the Contractor those payments described in the Payment Provisions (Exhibit B) which are attached hereto and are incorporated herein by reference, subject to all the terms and conditions contained or incorporated herein.

6. Authorized Representatives and Notices. This Contract is subject to the Authorized Representatives and Notices Provisions (Exhibit C) which are attached hereto and are incorporated herein by reference.

7. General Conditions. This Contract is subject to the General Conditions (Exhibit D) which are attached hereto and are incorporated herein by reference, subject to all the terms and conditions contained or incorporated herein.

8. Special Conditions. This Contract is subject to the Special Conditions (Exhibit E) (if any) which are attached hereto and are incorporated herein by reference, subject to all the terms and conditions contained or incorporated herein. (Note: other than Public Works contracts, the City will agree to Special Conditions only in unusual circumstances.)

9. Insurance Provisions. This Contract is subject to the Insurance Provisions (Exhibit F) which are attached hereto and are incorporated herein by reference.

10. Signatures. These signatures attest the parties' Contract hereto:

CITY OF RICHMOND
a municipal corporation

By: _____

Title:

I hereby certify that this Contract has been approved by City Council.

By: _____
City Clerk

Approved as to form:

By: _____
City Attorney

CONTRACTOR:

_____

(* The Corporation Chairperson of the Board, President or Vice President should sign below)

By: _____

Title: _____

Date Signed: _____

(* The Corporation Chief Financial Officer, Secretary or Assistant Secretary should sign below)

By: _____

Title: _____

Date Signed: _____

(NOTE: Pursuant to California Corporations Code Section 313, if Contractor is a corporation or nonprofit organization, this Contract (1) must be signed by (a) the Chairperson of the Board, President or Vice-President and (b) the Secretary any Assistant Secretary, the Chief Financial Officer or any Assistant Treasurer.

LIST OF ATTACHMENTS:

Service Plan	Exhibit A
Payment Provisions	Exhibit B
Authorized Representatives and Notices	Exhibit C
General Conditions	Exhibit D
Special Conditions	Exhibit E
Insurance Provisions	Exhibit F

For the Contract between the City of Richmond and

_____

EXHIBIT A
SERVICE PLAN

Contractor shall, to the satisfaction of the _____, perform the following services and be compensated as outlined below:

For the Contract between the City of Richmond and

EXHIBIT B
PAYMENT PROVISIONS

{PLEASE NOTE THAT THE CITY OF RICHMOND SHALL NOT PAY FOR SERVICES THAT EXCEED THE CONTRACT PAYMENT LIMIT UNLESS A CONTRACT AMENDMENT HAS BEEN APPROVED BY THE CITY COUNCIL OR THE CITY MANAGER}

1. Provided Contractor is not in default under this Contract, Contractor shall be compensated as provided below.

2. Any and all payments made pursuant to this Contract shall be subject to the Contract Payment Limit. The Payment Limit includes expenses (phones, photo copying, meals and travel etc). Invoices, shall be adequately detailed, based on accurate records, and be in a form reasonably satisfactory to the City. Contractor may be required to provide back-up material upon request.

3. Contractor shall submit timely invoices to the following address:

   Attention: City of Richmond, Finance Department - Accounts Payable
   Project Manager:_____ Department:_____
   PO Box 4046
   Richmond, CA 94804-0046

4. All invoices that are submitted by Contractor shall be subject to the approval of the City's Project Manager**,** _____ before payments shall be authorized.

5. The City will pay invoice(s) within 45 days after completion of services to the City's satisfaction. The City shall not pay late fees or interest.

6. A Richmond business license shall be obtained before any payment under this Contract shall be authorized and the business license must be kept current during the term of this Contract for payments to continue to be authorized.

7. All insurance coverage required by this Contract shall be provided by the Contractor before this Contract shall be executed by the City. The insurance coverage must be kept current during the term of this Contract for payments to continue to be authorized.

For the Contract between the City of Richmond and

_____

EXHIBIT C
AUTHORIZED REPRESENTATIVES AND NOTICES

1. Notices. All notices, demands, statements, or communications provided for by this Contract shall be in writing and may be delivered by deposit in the United States mail, postage prepaid. Notices to the City shall be addressed to the Department Head and (as delineated below in section 1.1) to the project manager responsible for the administration of or the supervision of the scope of work under this Contract. Notices to the Contractor shall be addressed to the party designated by Contractor (as delineated below in section 1.2). Notice shall be deemed delivered (a) upon personal delivery; (b) as of the fifth business day after mailing by United States certified mail, postage prepaid, addressed to the proper party; or (c) as of 12:00 p.m. on the second business day immediately after the day it is deposited with and accepted by Federal Express, or a similar overnight courier service, addressed to the proper party and marked for next business day morning delivery. For the purposes of this Contract, a "business day" means any day Monday through Friday that is not a holiday recognized by the federal government or the State of California.

1. 1 CITY hereby designates as its Authorized Representative the Project Manager whose name and address are as follows:

_____

City of Richmond

_____

Richmond, CA 94804-0046

1. 2 CONTRACTOR hereby designates as its Authorized Representative the Project Manager whose name and address are as follows:

_____

_____

_____

_____

EXHIBIT D
GENERAL CONDITIONS

1. Independent Contractor. Contractor acknowledges, represents and warrants that Contractor is not a regular or temporary employee, joint venturer or partner of the City, but rather an independent Contractor. This Contract shall not be construed to create an agency, servant, employee, partnership, or joint venture relationship. As an independent Contractor, Contractor shall have no authority to bind City to any obligation or to act as City's agent except as expressly provided herein. Due to the independent Contractor relationship created by this Contract, City shall not withhold state or federal income taxes, the reporting of which shall be Contractor's sole responsibility.

2. Brokers. Contractor acknowledges, represents and warrants that Contractor has not hired, retained or agreed to pay any entity or person any fee, commission, percentage, gift, or any other consideration, contingent upon or resulting from the award or making of this Contract.

3. City Property. The rights to applicable plans, drawings, reports, calculations, data, specifications, videos, graphics or other materials prepared for or obtained pursuant to this Contract, which, upon request, are to be delivered to City within a reasonable time, shall be deemed assigned to City. If applicable, Contractor shall prepare check prints upon request. Notwithstanding the foregoing, Contractor shall not be obligated to provide to City proprietary software or data which Contractor has developed or had developed for Contractor's own use; provided, however, that Contractor shall, pursuant to Section 15 below, indemnify, defend and hold harmless City from and against any discovery or Public Records Act request seeking the disclosure of such proprietary software or data.

4. Patents, Trademarks, Copyrights and Rights in Data. Contractor shall not publish or transfer any materials, discoveries, developments, concepts, designs, ideas, know how, improvements, inventions and/or original works of authorship resulting from activities supported by this Contract without the express prior written consent of the City Manager. If anything resulting from activities supported by this Contract is patentable, trademarkable, copyrightable or otherwise legally protectable, City reserves the exclusive right to seek such intellectual property rights. Notwithstanding the foregoing, Contractor may, after receiving City's prior written consent, seek patent, trademark, copyright or other intellectual property rights on anything resulting from activities supported by this Contract. However, City reserves, and Contractor irrevocably grants, a nonexclusive, fully paid-up, royalty-free, assumable, perpetual, worldwide license, with the right to transfer, sublicense, practice and exploit said license and the right to make, have made, copy, modify, make derivative works of, use, sell,

import, and otherwise distribute under all applicable intellectual properties without restriction of any kind said license.

Contractor further agrees to assist City, at City's expense, in every proper way to secure the City's rights in any patents, trademarks, copyrights or other intellectual property rights relating thereto, including the disclosure to City of all pertinent information and data with respect thereto. Contractor shall also assist City in the execution of all applications, specifications, oaths, assignments, recordations, and all other instruments which City shall deem necessary in order to apply for, obtain, maintain and transfer such rights, or if not transferable, to waive such rights. Contractor shall further assist City in the execution of all applications, specifications, oaths, assignments, recordations and all other instruments which City shall deem necessary in order to assign and convey to City, and any assigns and nominees the sole and exclusive right, title and interest in and to any patents, trademarks, copyrights or other intellectual property rights relating thereto. Contractor further agrees that its obligation to execute or cause to be executed, when it is in Contractor's power to do so, any such instruments or papers shall continue during and at all times after the end of Contractor's services and until the expiration of the last such intellectual property right. Contractor hereby irrevocably designates and appoints City, and its duly authorized officers, agents and servants, as its agent and attorney-in-fact, to act for and in its behalf and stead to execute and file any such applications and to do all other lawfully permitted acts to further the application for, prosecution, issuance, maintenance or transfer of letters of patents, copyright and other registrations. This power of attorney is coupled with an interest and shall not be affected by Contractor's subsequent incapacity.

5. Inspection. Contractor's performance, place of business and records pertaining to this Contract are subject to monitoring, inspection, review and audit by authorized representatives of the CITY, the State of California, and the United States Government.

   If the project or services set forth in Exhibit A shall be performed on City or other public property, City shall have the right to inspect such work without notice. If such project or services shall not be performed on City or other public property, City shall have the right to inspect such work upon reasonable notice.

6. Services. The project or services set forth in Exhibit A shall be performed to the full satisfaction and approval of City. In the event that the project or services set forth in Exhibit A are also itemized by price, City, in its sole discretion, may, upon notice to Contractor, delete certain items or services set forth in Exhibit A, in which case there shall be a corresponding reduction in the amount of compensation paid to Contractor.

Contractor shall, at its own cost and expense, furnish all facilities and equipment necessary for Contractor to complete the project or perform the services required herein, unless otherwise provided in Exhibit A.

7. Records. Contractor shall keep and make available for inspection and copying by authorized representatives of the City, the State of California, and the United States Government, the Contractor's regular business records and such additional records pertaining to this Contract as may be required by the City.

   Contractor shall retain all documents pertaining to this Contract for a period of five (5) years after this Contract's termination (or for any further period that is required by law) and until all Federal or State audits are complete and exceptions resolved for this contract's funding period. Upon request, CONTRACTOR shall make these records available to authorized representatives of the CITY, the State of California, and the United States Government.

   Contractor shall keep full and detailed accounts, maintain records, and exercise such controls as may be necessary for proper financial management under this Contract. The Contractor's accounting and control systems shall be satisfactory to City. Contractor's accounting systems shall conform to generally accepted accounting principles and all records shall provide a breakdown of total costs charged under this Contract, including properly executed payrolls, time records, utility bills, invoices and vouchers. The City shall be afforded prompt access to Contractor's records, books, and Contractor shall preserve such project records for a period of at least five (5 years after the termination of this Contract , or for such longer period as may be required by law.

   Contractor shall permit City and its authorized representatives and accountants to inspect, examine and copy Contractor's books, records, accounts, correspondence, instructions, drawings, receipts, subcontracts, purchase orders, vouchers, memoranda and other data relating to the project or services set forth in Exhibit A, and any and all data relevant to this Contract at any reasonable time for the purpose of auditing and verifying statements, invoices, or bills submitted by Contractor pursuant to this Contract and shall provide such assistance as may be reasonably required in the course of such inspection. Contractor shall also allow City access to the record keeping and accounting personnel of Contractor. City further reserves the right to examine and re-examine said books, records, accounts, and data during the five (5 year period following the termination of this Contract; and Contractor shall in no event dispose of, destroy, alter, or mutilate said books, records, accounts, and data in any manner whatever for five (5 years after the termination of this Contract.

Pursuant to California Government Code § 10527, the parties to this Contract shall be subject to the examination and audit of representatives of the Auditor General of the State of California for a period of three (3) years after final payment under this Contract. The examination and audit shall be confined to those matters connected with the performance of this Contract including, but not limited to, the cost of administering this Contract.

8. Changes and Extra Work. All changes and/or extra work under this Contract shall be performed and paid for in accordance with the following:

   Only the City Council or the City Manager may authorize extra and/or changed work. Contractor expressly recognizes that other City personnel are without authorization to either order extra and/or changed work or waive contract requirements. Failure of Contractor to secure the authorization for such extra and/or changed work shall constitute a waiver of any and all right to adjustment in contract price due to such unauthorized work and Contractor thereafter shall be entitled to no compensation whatsoever for performance of such extra and/or changed work.

   If Contractor is of the opinion that any work which Contractor has been directed to perform is beyond the scope of this Contract and constitutes extra work, Contractor shall promptly notify City of the fact. The City shall make a determination as to whether or not such work is, in fact, beyond the scope of this Contract and constitutes extra work. In the event that City determines that such work does constitute extra work, City shall provide extra compensation to Contractor on a fair and equitable basis. A change order or Contract Amendment providing for such compensation for extra work shall be negotiated between City and Contractor and executed by Contractor and the appropriate City official.

   In the event City determines that such work does not constitute extra work, Contractor shall not be paid extra compensation above that provided herein and if such determination is made by City staff, said determination may be appealed to the City Council; provided, however, a written appeal must be submitted to the City Manager within five (5) days after the staff's determination is sent to Contractor. Said written appeal shall include a description of each and every ground upon which Contractor challenges the staff's determination.

9. Additional Assistance. If this Contract requires Contractor to prepare plans and specifications, Contractor shall provide assistance as necessary to resolve any questions regarding such plans and specifications that may arise during the period of advertising for bids, and Contractor shall issue

any necessary addenda to the plans and specifications as requested. In the event Contractor is of the opinion that City's requests for addenda and assistance is outside the scope of normal services, the parties shall proceed in accordance with the changes and extra work provisions of Section 8 of these General Conditions.

10. Professional Ability. Contractor acknowledges, represents and warrants that Contractor and its employees are skilled and able to competently provide the services hereunder, and possess all professional licenses, certifications, and approvals necessary to engage in their occupations. City has relied upon the professional ability and training of Contractor as a material inducement to enter into this Contract. Contractor shall perform in accordance with generally accepted professional practices and standards of Contractor's profession. In the event that City, in its sole discretion, desires the removal of any person employed or retained by Contractor to perform services hereunder, such person shall be removed immediately upon receiving notice from City.

11. Business License. Contractor shall obtain a Richmond Business License before performing any services required under this Contract. The failure to so obtain such license shall be a material breach of this Contract and grounds for immediate termination by City; provided, however, that City may waive the business license requirement in writing under unusual or extraordinary circumstances without necessitating any modification of this Contract to reflect such waiver.

12. Termination Without Default. Notwithstanding any provision herein to the contrary, City may, in its sole and absolute discretion and without cause, terminate this Contract at any time prior to completion by Contractor of the project or services hereunder, immediately upon written notice to Contractor. Contractor may terminate this Contract at any time in its sole and absolute discretion and without cause upon 30 days' written notice to City. In the event of termination by either party, Contractor shall be compensated for: (1) all authorized work satisfactorily performed prior to the effective date of termination; (2) necessary materials or services of others ordered by Contractor for this Contract, prior to receipt of notice of termination, irrespective of whether such materials or services of others have actually been delivered, provided that Contractor is not able to cancel such orders. Compensation for Contractor in such event shall be determined by City in accordance with the percentage of the project or services completed by Contractor; and all of Contractor's finished or unfinished work product through the time of the City's last payment shall be transferred and assigned to City. Additionally, in the event of such termination, the City may proceed with the work in any reasonable manner it chooses.

13. Termination in the Event of Default. Should Contractor fail to perform any of its obligations hereunder, within the time and in the manner provided or otherwise violate any of the terms of this Contract, City may immediately terminate this Contract by giving written notice of such termination, stating the reasons for such termination. Contractor shall be compensated as provided in Section 12 of these General Conditions; provided, however, there shall be deducted from such amount the amount of damage, including attorney's fees, expert witness fees and costs, if any, sustained by City by virtue of Contractor's breach of this Contract. Additionally, in the event of such termination, the City may proceed with the work in any reasonable manner it chooses.

14. Conflict of Interest. Contractor acknowledges, represents and warrants that Contractor shall avoid all conflicts of interest (as defined under any federal, state or local statute, rule or regulation, or at common law) with respect to this Contract. Contractor further acknowledges, represents and warrants that no City official or employee has any economic interest, as defined in Title 2, California Code of Regulations §§ 18703.1 through 18703.5, with Contractor that would invalidate this Contract. Contractor acknowledges that in the event that Contractor shall be found by any judicial or administrative body to have any conflict of interest (as defined above) with respect to this Contract, all consideration received under this Contract shall be forfeited and returned to City forthwith. This provision shall survive the termination of this Contract for one (1) year.

15. Indemnification.

(a) If this Contract is a contract for design professional services subject to California Civil Code Section 2782.8(a) and Contractor is a design professional, as defined in California Civil Code Section 2782.8(b)(2), Contractor shall hold harmless, defend and indemnify the City, its officers, agents, employees, and volunteers from and against any and all claims, damages, losses, and expenses including attorneys' fees arising out of, or pertaining to, or relating to the negligence, recklessness, or willful misconduct of the Contractor, except where caused by the active negligence, sole negligence, or willful misconduct of the City. To the fullest extent permitted by law, Contractor shall immediately defend and indemnify the City and its officers, agents, employees, and volunteers from and against any and all liabilities, regardless of nature or type, that arise out of, pertain to, or relate to the negligence, recklessness, or willful misconduct of the Contractor, or its employees, agents, or subcontractors. Liabilities subject to the duties to defend and indemnify include, without limitation, any and all claims, losses, damages, penalties, fines, and judgments; associated investigation and administrative expenses; defense costs, including but not limited to reasonable attorneys' fees; court costs; and costs of alternative dispute resolution. Contractor's obligation to

indemnify applies unless it is finally adjudicated that the liability was caused by the sole active negligence or sole willful misconduct of an indemnified party.

(b) If this Contract is not a contract for design professional services subject to California Civil Code Section 2782.8(a) or Contractor is not a design professional as defined in California Civil Code Section 2782.8(b)(2), Contractor shall indemnify, defend, and hold harmless the City, its officers, agents, employees and volunteers from any and all claims, suits, or actions of every name, kind and description, brought forth on account of injuries to or death of any person or damage to property arising from or connected with the willful misconduct, negligent acts, errors or omissions, ultra-hazardous activities, activities giving rise to strict liability, or defects in design by Contractor or any person directly or indirectly employed by, or acting as, the agent for Contractor in the performance of this Contract, including the concurrent or successive passive negligence of the City, its officers, agents, employees or volunteers.

(c) It is understood that the duty of Contractor to indemnify and hold harmless includes the duty to defend as set forth in Section 2778 of the California Civil Code. Contractor shall be obligated to defend, in all legal, equitable, administrative, or special proceedings, with counsel approved by the City, the City and its officers, agents, employees, and volunteers, immediately upon tender to Contractor of the claim in any form or at any stage of an action or proceeding, whether or not liability is established. An allegation or determination that persons other than Contractor are responsible for the claim does not relieve Contractor from its separate and distinct obligation to defend under this Section 15. The obligation to defend extends through final judgment, including exhaustion of any appeals. The defense obligation includes an obligation to provide independent counsel if Contractor asserts that liability is caused in whole, or in part, by the negligence or willful misconduct of an indemnified party.

(d) The review, acceptance or approval of the Contractor's work or work product by any indemnified party shall not affect, relieve or reduce the Contractor's indemnification or defense obligations. This Section 15 survives completion of the services or the termination of this Contract. The provisions of this Section 15 are not limited by, and do not affect, the provisions of this Contract relating to insurance.

(e) Acceptance of insurance certificates and endorsements required under this Contract does not relieve Contractor from liability under this Section 15. This Section 15 shall apply whether or not such insurance policies are determined to be applicable to any such damages or claims for damages.

16. Safety. Contractor acknowledges that the City is committed to the highest standards of workplace safety. Contractor shall perform all work hereunder in full compliance with applicable local, state and federal safety requirements including but not limited to Occupational Safety and Health Administration requirements, and shall assume sole and complete

responsibility for the safety of Contractor's employees and any subContractor's employees. If a death, serious personal injury or substantial property damage occurs in connection with the performance of this Contract, Contractor shall immediately notify the City by telephone.

17. Insurance. Insurance requirements are set forth in Exhibit F to this Contract. Contractor shall abide by the insurance requirements set forth in said Exhibit F.

18. Non-Liability of Officials and Employees of the City. No official or employee of the City shall be personally liable for any default or liability under this Contract.

19. Compliance with Laws. Contractor shall comply with all federal, state and local laws, statutes, ordinances, rules and regulations, and the orders and decrees of any courts or administrative bodies or tribunals, with respect to this Contract, including without limitation environmental laws, employment discrimination laws and prevailing wage laws. Compliance under this provision includes compliance with all provisions of the Richmond Municipal Code ("Municipal Code"), including Chapters 2.50, 2.52, 2.56, and 2.60, if applicable.

    Contractor acknowledges that under § 2.60.070 of the Municipal Code ("Living Wage Ordinance"), Contractor shall promptly provide to City documents and information verifying its compliance with the Living Wage Ordinance. Also as prescribed in § 2.60.070, Contractor shall notify each of its affected employees with regards to the wages that are required to be paid pursuant to the Living Wage Ordinance.

    Contractor shall comply with § 2.28.030 of the Municipal Code, obligating every Contractor or subcontractor under a contract or subcontract with the City for public work or for goods or for services to refrain from discriminatory employment or subcontracting practices on the basis of race, color, sex, sexual orientation, religious creed, national origin or ancestry of any employee, any applicant for employment or any potential subcontractor.

    Contractor acknowledges that the City's Drug Free Workplace Policy, Violence in the Workplace Policy and the Policy Against Workplace Harassment, are available on the City's website at http://www.ci.richmond.ca.us/workplacepolicies . Contractor agrees to abide by the terms and conditions of said policies.

20. Limitations upon Subcontracting and Assignment. This Contract binds the heirs, successors, assigns and representatives of Contractor. The Contractor shall not enter into subcontracts for any work contemplated

under this Contract and shall not assign this Contract, nor any portion hereof or monies due or to become due, without the prior written consent of the City Council or its designee.

Contractor acknowledges that the services which Contractor shall provide under this Contract are unique, personal services which, except as otherwise provided herein, Contractor shall not assign or sublet to any other party without the prior written approval of City, which approval may be withheld in City's sole and absolute discretion. In the event that City, in writing, approves any assignment or subletting of this Contract or the retention of subcontractors by Contractor, Contractor shall provide to City upon request copies of each and every subcontract contract prior to the execution thereof by Contractor and subcontractor. Any assignment by Contractor of any or all of its rights under this Contract without first obtaining City's prior written consent shall be a default under this Contract.

The sale, assignment, transfer or other disposition of any of the issued and outstanding capital stock of Contractor (if applicable), or of the interest of any general partner or joint venturer or syndicate member if Contractor is a partnership or joint-venture or syndicate, which shall result in a change of control of Contractor, shall be deemed an assignment. For this purpose, control shall mean fifty percent or more of the voting power or twenty-five percent or more of the assets of the corporation, partnership or joint-venture.

21. Integration. This Contract constitutes the entire agreement between the parties concerning the subject matter hereof and supersedes any previous oral or written agreement; provided, however, that correspondence or documents exchanged between Contractor and City may be used to assist in the interpretation of the Exhibits to this Contract.

22. Modifications and Amendments. This Contract may be modified or amended only by a change order or Contract Amendment executed by both parties and approved as to form by the City Attorney.

23. Conflicting Provisions. In the event of a conflict between these General Conditions and those of any Exhibit or attachment hereto, these General Conditions shall prevail; provided, however, that any Special Conditions as set forth in Exhibit E shall prevail over these General Conditions. In the event of a conflict between the terms and conditions of any two or more Exhibits or attachments hereto, those prepared by City shall prevail over those prepared by the Contractor, and the terms and conditions preferred by the City shall prevail over those preferred by the Contractor.

24. Non-exclusivity. Notwithstanding any provision herein to the contrary, the services provided by Contractor hereunder shall be non-exclusive, and

City reserves the right to employ other Contractors in connection with the project.

25. Exhibits. All Exhibits hereto are made a part hereof and incorporated herein by reference; provided, however, that any language in Exhibit A which does not pertain to the project description, proposal, scope of services, or method of compensation (as applicable) , or any corresponding responsibilities of City, shall be deemed extraneous to, and not a part of, this Contract.

26. Force Majeure. Neither party hereto shall be considered in default in the performance of its obligations hereunder to the extent that the performance of such an obligation is prevented or delayed by reason of acts of God, strikes, boycotts, lock-outs, inability to procure materials not related to the price thereof, failure of power, restrictive governmental laws and regulations enacted after the date of this Contract, riots, civil unrest, acts of terrorism, insurrection, war, declaration of a state or national emergency or other reasons of a like nature not within the reasonable control of such party.

27. Time of the Essence. Time is of the essence of this Contract. Contractor and City agree that any time period set forth in Exhibit A represents their best estimates with respect to completion dates and both Contractor and City acknowledge that departures from the schedule may occur. Therefore, both Contractor and City will use reasonable efforts to notify one another of changes to the schedule. Contractor shall not be responsible for performance delays caused by others, or delays beyond Contractor's control, and such delays shall extend the times for performance of Contractor's work.

28. Confidentiality. Contractor agrees to comply with, and to require its employees, agents and partners to comply with, all applicable State or Federal statutes or regulations respecting confidentially, including but not limited to, the identity of persons served under this Contract, their records, or services provided them, and assures that:

    All applications and records concerning any individual made or kept by Contractor or any public officer or agency in connection with the administration of or relating to services provided under this Contract will be confidential, and will not be open to examination for any purposes not directly connected with the administration of such service.

    No person will publish or disclose or permit or cause to be published or disclosed, any list of persons receiving services, except as may be required in the administration of such service.

29. Third Parties. Nothing herein shall be interpreted as creating any rights or benefits in any third parties. For purposes hereof, transferees or assignees as permitted under this Contract shall not be considered "third parties."

30. Governing Law. This Contract shall be construed in accordance with the law of the State of California without regard to principles of conflicts of law. This Contract is made in Contra Costa County, California, and any action relating to this Contract shall be instituted and prosecuted in the courts of Contra Costa County, California.

31. Nonrenewal. Contractor understands and agrees that there is no representation, implication, or understanding that the services provided by Contractor under this Contract will be purchased or renewed by the City under a new contract following expiration or termination of this Contract, and waives all rights or claims to notice or hearing respecting any failure by City to continue the purchase of all or any failure to continue purchase of all or any such services from Contractor.

32. Claims. Any claim by Contractor against City hereunder shall be subject to Government Code §§ 800 et seq. The claims presentation provisions of said Act are hereby modified such that the presentation of all claims hereunder to the City shall be waived if not made within six months after accrual of the cause of action.

33. Interpretation. This Contract shall be interpreted as if drafted by both parties.

34. Warranty. In the event that any product shall be provided to the City as part of this Contract, Contractor warrants as follows: Contractor possesses good title to the product and the right to transfer the product to City; the product shall be delivered to the City free from any security interest or other lien; the product meets any specifications contained herein; the product shall be free from material defects in materials and workmanship under normal use for a period of one (1) year from the date of delivery; and the product shall be fit for its intended purpose(s). Notwithstanding the foregoing, consumable and maintenance items (such as light bulbs and batteries) shall be warranted for a period of one hundred and eighty (180) days from the date of delivery. All repairs during the warranty period shall be promptly performed by Contractor, at Contractor's expense, including shipping.

35. Severability. In the event that any of the provisions or portions or applications thereof of this Contract are held to be unenforceable or invalid by any court of competent jurisdiction, City and Contractor shall negotiate an equitable adjustment in the provisions of the Contract with a view

toward effecting the purpose of this Contract, and the validity and enforceability of the remaining provisions or portions or applications thereof, shall not be affected thereby.

36. Authority. City warrants and represents that the signatory hereto (the Mayor of the City of Richmond or the City Manager) is duly authorized to enter into and execute this Contract on behalf of City. The party signing on behalf of Contractor warrants and represents that he or she is duly authorized to enter into and execute this Contract on behalf of Contractor, and shall be personally liable to City if he or she is not duly authorized to enter into and execute this Contract on behalf of Contractor.

37. Waiver. The waiver by City of any breach of any term or provision of this Contract shall not be construed as a waiver of any subsequent breach. Inspections or approvals, or statements by any officer, agent or employee of the City relating to the Contractor's performance, or payments therefore, or any combination of these acts, shall not relieve the Contractor's obligation to fulfill this Contract as prescribed; nor shall the City be thereby stopped from bringing any action for damages or enforcement arising from any failure to comply with any of the terms and conditions of this Contract.

38. Possessory Interest. If this Contract results in the Contractor having possession of, claim to or right to the possession of land or improvements, but does not vest ownership of the land or improvements in the same person, or if this Contract results in the placement of taxable improvements on tax exempt land (Revenue and Taxation Code 107), such interest or improvements may represent a possessory interest subject to property tax, and Contractor may be subject to the payment of property taxes levied on such interest.

39. Performance and Final Acceptance.

    Contractor represents that it is experienced, qualified, registered, licensed, equipped, organized and financed to perform the services under this Contract.

    Contractor shall perform the services under this Contract with that degree of skill and judgment normally exercised by professional firms performing services of a similar nature in the State of California, and shall be responsible for the professional quality, technical accuracy and coordination of the services it performs under this Contract. In addition to the other rights and remedies which City may have, Contractor shall, at its own expense, correct any services which fail to meet the above standard.

City shall provide Contractor an opportunity to cure errors and omission which may be disclosed during the review of submittals, with no increase in the authorized Contract Payment Limit. Should Contractor fail to make necessary corrections in a timely manner, such corrections shall be made by the City and the cost thereof shall be charged to Contractor.

If warranted, City shall determine, and Contractor may request such determination, that Contractor has satisfactorily completed performance of this Contract. Upon such determination, City shall issue to Contractor a written Notice of Final Acceptance, after which Contractor shall not incur further costs under this Contract. Contractor shall respond to such Notice of Final Acceptance by executing and submitting to City a Release and Certificate of Final Payment.

40. Survival. The rights and obligations of the parties which by their nature survive termination or completion of the services covered by this Contract shall remain in full force and effect after termination or completion.

For the Contract between the City of Richmond and

EXHIBIT E
SPECIAL CONDITIONS

The General Conditions are hereby amended to include the following modifications and/or provisions (if applicable):

For the Contract between the City of Richmond and

EXHIBIT F
INSURANCE PROVISIONS

During the entire term of this Contract and any extension or modification thereof, the CONTRACTOR shall keep in effect insurance policies meeting the insurance requirements specified in the insurance provisions which are attached hereto and incorporated herein by this reference.

March 22, 2022

PROPOSAL FOR

CITY OF Richmond CALIFORNIA

City Of Richmond Third Party Workers' Compensation Claims Administration and Managed Care Services

ELECTRONIC COPY

AIMS SM
ACCLAMATION INSURANCE MANAGEMENT SERVICES

ALLIED MANAGED CARE INCORPORATED SM

Contact: Lynn Cavalcanti, Sr. VP Operations
10445 Old Placerville Road, Sacramento, CA 95827
Phone: (916) 563-1900
lcavalcanti@aims4claims.com

COVER LETTER

March 22, 2022

Laura Marquez, Risk Management
City of Richmond / Human Resources Department
Risk Management Division

Re: Request for Proposal for Third Party Workers' Compensation Claims Administration and Managed Care Services

Dear Mrs. Marquez:

We value the relationship we have established with the City of Richmond ("City") over the past nine plus years. This relationship involves a high level of communication, trust, and commitment. It has evolved into a true partnership, which is imperative to the success of its program.

Acclamation Insurance Management Services, Inc. (AIMS) is submitting this proposal in the hopes of continuing this partnership to provide services related to the City's Workers' Compensation Program. We believe the following proposal response to the City's Request for Proposal (RFP), will not only meet but exceed the identified requirements.

As a Third Party Administrator (TPA), **AIMS** is the industry-leading preferred provider of Loss Portfolio Management® services. **AIMS** is part of the wholly owned subsidiary organization of LJR Holdings, Inc. (LJRH), which began as a family business and was originally founded in 1973 as Leonard J. Russo Insurance Services, Inc. LJRH is a privately held/owned organization incorporated in the State of California. Services include claims administration (both workers' compensation and liability) via **AIMS** and medical cost containment via our sister company, **Allied Managed Care (AMC)**, for both public and private entities which includes those organizations that are self-insured, self-administered, throughout the Continental United States and Hawaii. AIMS currently has 183 employees and AMC has 73 employees for a total of 266.

AIMS currently has over 230 Clients throughout California that range in size from small utility districts, many mid-sized Cities, to a Joint Powers Authority (JPA), which consists of 53 cities. We have been providing claims administration services for two-thirds of these Clients for greater than 10 years and 80 percent of our clients are Public Entities. We currently administer over 12,000 open claims for our California-based Clients. Organizationally, we have a tremendous level of expertise in working with self-insured public agencies. Our technical personnel are well versed and trained in those special areas of workers' compensation that relate to public employees, safety officers / firefighters (4850), multiple salary continuation scenarios, Public Employee Retirement System (PERS) and other public employee retirement programs and union involvement.

We have continued to partner with the City of Richmond to transition their Police Department ADR Program back into the Statutory System, which was a first for everyone (the State, City of Richmond and AIMS). And we continue to work with the City of Richmond to improve the Fire Department's Program by providing alternative solutions to

the ADR process. We are excited with the possibility to continue this work with the City of Richmond.

AIMS has a total of eight (8) office locations. Seven (7) of the offices are located in California, two (2) offices in Sacramento, (Corporate Office and Branch Office), Concord Office, Fresno Office, Bakersfield Office, Santa Clarita Office and Pomona Office. We also have a branch office in Honolulu Hawaii.

The **AIMS** Concord Office located at 1819 Willow Pass Road, Concord Ca 94521, Phone: 925-687-2822, our closest office to the City of Richmond will continue to service The City's Program if we are the successful bidder.

Our senior operating management team has reviewed the City's RFP in detail including the sections pertaining to the Introduction, Minimum Qualifications, Scope of Services, Proposal Requirements, Insurance Requirements, as well as the City Ordinances, Standard Services Agreement and the contents in between. Our management team has determined that we can and will fully comply with the RFP requirements as outlined without exception.

Our proposal reflects our continued commitment to provide the City with superior services and competitive rates and is valid for at least 180 days. We strongly believe, based on the experience of our team, that our solutions and work practices provide the City with excellent value. The quality of our service and our reputation can be confirmed by the references we've listed in our proposal.

Our designated contact for the City and for this response is Lynn Cavalcanti, Sr. VP Operations **AIMS**. The location of our Corporate Office and Lynn's contact information is 10445 Old Placerville Road, Sacramento, CA 95827 / Direct: (707) 685-1138 or Corporate Office: (916) 563-1900 x259 / Email: lcavalcanti@aims4claims.com.

As the person legally authorized to bind **AIMS** to the requirements in the City's RFP, the City of Richmond can be assured it will have my full support and commitment that we can and will deliver as promised. I am always be available not only to respond to any problems or concerns but to share my insight on our solutions and offerings. Please feel free to contact me directly. I can be reached directly at (916) 563-1900 x207 / Toll free: (800) 444-4157 / Email: drusso@aims4claims.com.

Also, **AIMS** would be delighted for an opportunity to answer any questions you may have regarding our RFP response and to further explore how we can customize a solution to enhance the overall success of the City's program.

Sincerely,

Dominic L. Russo, President & CEO AIMS

Our Proposal

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EXHIBITS

EXHIBIT 12 – URAC Reports

EXHIBIT 13 – UR Audits (CONFIDENTIAL)

EXHIBIT 14 – Certificate of Insurance

EXHIBIT 15 – PROPOSER QUALIFICATIONS

PROPOSAL FORMAT GUIDELINES

The proposal should be concise, well organized, and demonstrate the proposer's qualifications and experience applicable to the Project. The proposal shall be limited to 15 double-sided pages (8.5 inches x 11 inches), inclusive of graphics, forms, pictures, photographs, dividers, etcetera, but not of cost proposal, resumes, required forms, certifications, front and back covers, or letters of commitment from sub-consultants. The required font size is 12 point, with minimum left and right margins of one-inch, and top and bottom margins of 0.7 inches.

Each proposal will adhere to the following order and content of sections. Proposal should be straightforward, concise and provide "layman" explanations of technical terms that are used. Emphasis should be concentrated on conforming to the RFP instructions, responding to the RFP requirements, and on providing a complete and clear description of the offer.

AIMS responses to the City of Richmond ("City") Request for Proposal (RFP) questions follow the guidelines specified in the City's RFP to provide "Third Party Workers' Compensation Claims Administration and Managed Care Services". The RFP text has been extracted verbatim and is in black font and AIMS responses are in a blue 12-point Arial font.

The AIMS management team has reviewed the conditions identified in this section and implicitly agrees to them. We believe our proposal is complete and none of our responses are conditional. If there is a question about the interpretation of one our responses, AIMS would welcome the opportunity to address and provide clarification for the City.

Also, we capitalize the word, "Client" in our answers to signify the integral role and respect we have for these relationships.

Proposals, which appear unrealistic in the terms of technical commitments, lack of technical competence or are indicative of failure to comprehend the complexity and risk of this contract, may be rejected. The following proposal sections are to be included in the Vendor's response

A. Vendor Cover Letter

A cover letter, not to exceed three pages in length, should summarize key elements of the proposal and shall:

- Confirm that all elements of this RFP have been reviewed and understood.
- Include a statement of intent to perform the services as outlined.
- Express company's willingness to enter into an agreement under the terms and conditions prescribed by this RFP, insurance requirements and in the sample City or Richmond Standard Contract (Services Agreement).
- Submit a written description and brief history of the company's experiences, qualifications and successes in providing California services described

herein. Please indicate the number of employees, client base and location of offices.
- Indicate the address and telephone number of the vendor's office located nearest to Richmond, California and the office from which the project will be managed.
- Confirm that vendor has a minimum of three (3) years verifiable California experience.
- Stipulate that the proposal price will be valid for a period of at least 180 days.
- Identify a single person for contact during the RFP review process; and
- Cover letter shall be signed by an authorized official of the company.

Our *Cover Letter* precedes this content and includes the name of Lynn Cavalcanti, Sr. VP Operations, who may be contacted during the evaluation period. The requested information is provided below.

- NAME / TITLE: Lynn Cavalcanti, Sr. VP Operations
- ADDRESS: 10445 Old Placerville Road, Sacramento, CA 95827
- EMAIL: lcavalcanti@aims4claims.com
- PHONE: Direct (707) 685-1138 or Corporate Office (916) 563-1900 x259

Also, our *Cover Letter* is signed by Dominic Russo, President & CEO of AIMS/Allied Managed Care, Inc. (AMC). As an officer of the Company, Dominic is authorized to bind the offering of services and cost terms provided in our proposal. His contact information is provided in the cover letter as requested.

B. Background and Project Summary Section

The Background and Project Summary Section should describe your understanding of the City, the work to be done, and the objectives to be accomplished. Refer to description of services for this RFP.

Background: LJR Holdings, Inc. (LJRH) was incorporated in July 1996 in California to act as a holding company for its wholly owned operating subsidiaries: **Acclamation Insurance Management Services, Inc. (AIMS)** and Allied Managed Care, Inc. (AMC), collectively the "Company". As the parent organization to AIMS and AMC, LJRH provides all corporate services to its subsidiaries such as Finance, Human Resources, Information Technology/Support, Marketing and Sales, and Client Information Services. LJRH does not generate revenues and is supported by allocation methodology from its subsidiary companies.

The Company was originally founded in 1973 as Leonard J. Russo Insurance Services, Inc. In January of 1990 there was a name change to Acclamation Insurance Management Services, Inc. (AIMS) to better reflect the diverse nature of our product offering. AIMS was incorporated in California in March 1990 in conjunction with and just after the name change.

The Company is a diversified service firm, which provides claims services, cost containment, and risk-management information services to insurance companies, self-insured corporations, and government entities throughout the continental United States and Hawaii.

The Company is a family-owned business and primary ownership is divided amongst the immediate family members. Leonard Russo, Chairman of the Board and Dominic Russo, President & CEO are the majority shareholders.

AIMS is a Third Party Administrator (TPA) and the industry-leading preferred provider of Loss Portfolio Management® services, including claims administration (both workers' compensation and liability) and full service medical cost containment management through our sister company, AMC. AIMS is incorporated in the State of California and as a corporation, has a board of directors and corporate officers.

AIMS has built a reputation as being one of California's most progressive, Client-centric third party claims administrators in managing employer workers' compensation loss portfolios. AIMS currently has over *100 Clients throughout California* ranging in size from small utility districts to a Joint Powers Authority (JPA) consisting of 53 cities and all sizes in between. AIMS has been providing claims administration services for two-thirds of these Clients for greater than 10 years.

Managed Care: After having worked with other medical management firms, AIMS found that none had a thorough understanding of the needs of a workers' compensation claims administrator and encouraged its parent company, LJRH, to form a managed care company. So, in 1995, Allied Managed Care, Inc. (AMC) was formed. AMC was first established and incorporated in California in July 1995 to provide professional medical cost containment. Having its finger on the pulse of the workers' compensation administration issues has put AMC management in a uniquely informed and unique position when it comes to designing programs that improve claims administration workflows and reduce costs while improving injured employee outcomes.

AMC offers Medical Bill Review, Preferred Provider Organization (PPO) networks, Utilization Review (UR), Nurse Case Management (including telephonic and on-site or field nurse case management), customized Medical Provider Networks (MPN), AlliedRx (Prescription Management), AlliedCare Complete (Early Intervention), and CallConnect (Call Center Services).

Qualifications: AIMS currently administers over 12,000 open indemnity claims for our Clients that are based in California. AIMS focus is to provide a program that reinforces

the strategic goals of workforce excellence, organizational effectiveness, and fiscal responsibility.

- As a California based business, we specialize in the management of California workers' compensation claims; we focus on identifying, addressing, and managing all areas of the workers' compensation program and focused on issues that are more relevant to Clients based in California.
- As a privately held company, we bring a transparent approach to establishing TPA programs; a unique skill set, and a different perspective versus national and publicly held third party administrators.
- All AIMS offices are certified by the State of California to administer workers' compensation claims by Self Insurance Plans.

AIMS distinguishes itself from other TPA/Managed Care organizations not only by its dedication to providing superior Client service but by its **"Loss Portfolio Management®"** approach to managing claims programs, which is an overall "management of assets" approach as opposed to merely processing one claim at a time. A true partnership between the Client and the administrator is imperative to the successful management of a workers' compensation program. Our **"Loss Portfolio Management®"** approach ensures that we are always focused on identifying key issues that have a large financial impact on overall claim costs and to proactively utilize all available internal and external cost containment resources to resolve these issues in an expedient fashion. As a Client-driven organization, we deliver measurable financial results to our Clients through intelligent use of innovative technology and a flexible, yet disciplined approach to service delivery with fiscal accountability.

Quality Control (QC) Program: AIMS asserts a strong Quality Control Program, in which we consistently monitor, measure performance, and review the quality of the services being provided to ensure superior Client service and cost saving results for our Clients. In addition to the standard supervisory audit, our Internal Audit Unit, headed by Cheryl Agee (Vice President of Workers' Compensation) will conduct audits against our best practice standards as well as the Client's *Special Handling Instructions*. The Audit Unit's process involves notification that an audit is to be conducted in the Branch or local office. The Manager will make available all requested information, claim files, logs, contracts, etc. In addition, the Manager shall participate in the actual audit itself. All files with deficiencies and/or recommendations are immediately returned to the Claims Examiner for corrective action. The Claims Managers review the file for compliance at each diary date. The Supervisors carry independent diaries for this purpose. Audit scores are incorporated into Performance Evaluations conducted annually for each employee. The audit conducted by our internal audit unit is comprehensive and takes into consideration all facets of claim file handling.

AIMS will continue to meet with the City periodically to discuss specific file issues and all claim denials will be approved by the Claims Supervisor prior to the denial being made.

Rules and Regulation Updates: AIMS takes its commitment and responsibility to ensure its management of claims is in adherence with Workers Compensation Laws of California, Governing Statutes and Rules and Regulations of the Department of Industrial Relations, and Client Contract Service agreements while ensuring the appropriate delivery of benefits for injured workers.

To keep up on all legislative and regulatory updates that would affect our business, AIMS employs an independent Legislative Lobbyist/Advocate. AIMS' legislative advocate is based in Sacramento and their sole function is to serve as the eyes and ears for AIMS and our Clients. We lobby on behalf of our Clients. Having familiarity with numerous legislators as well as access to the Executive Branch of California State Government, the AIMS Legislative/Lobbyist Advocate has been instrumental in helping to shape policy in the workers' compensation arena on behalf of our Clients, both in the public and private sectors of industry. Their year-end report on passed and pending legislation is provided to our Clients at no additional cost and has been a valuable primer in keeping our Clients aware of the potential rules and regulations that affect workers' compensation in the State.

Medicare Second Payer: AIMS has a formal plan in place to comply with the mandatory reporting requirements of Section 111 ("Medicare Secondary Payer") of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA). AIMS' strategic partner provides Mandatory Insurer Reporting (MIR) Services to our Clients, including State Children's Health Insurance Program (SCHIP) reporting, and ensures MSP compliance. Our strategic partner is used for all Qualified Referrals (claim settlements determined to require a Medicare Set Aside (MSA), Claim Settlement Allocation (CSA) and other services related to MSP compliance identified in their fee schedule).

Audit Results: AIMS administers all claims for workers' compensation benefits in accordance with the requirements of the workers' compensation laws of the State of California. All AIMS offices are certified by the State of California to administer workers' compensation claims by Self Insurance Plans. Over the last 40 years, AIMS successfully passes audits conducted by Division of Workers' Compensation's Audit Unit, Self-Insurance Plans, California State Association of Counties/Excess Insurance Authority (CSAC-EIA), Local Agency Workers' Compensation Excess Joint Powers Authority (LAWCX), other excess carriers, and Client specific auditors. This demonstrates AIMS qualifications to administer claims in full accordance of applicable rules, regulations, laws, and the City's Scope of Work to be performed and standards to be followed.

Vendor Panel: *AIMS can provide the City with the flexibility to customize a vendor panel* or we can recommend vendors that have historically provided the best outcome for our Clients. This approach to claims administration has yielded a significant reduction in program costs and overall better results for our Clients. AIMS does not have any limitation in working with outside vendors. Our objective is to help our Client obtain the best value for the needed service.

Carve-Outs: AIMS has expertise and experience in working with our Clients in developing Carve-Outs programs (Alternative Dispute Resolution or ADR). By working

with our Clients, Unions and employees there is the opportunity to alter the adversarial culture of the worker's compensation claims process which could result in reducing cost to our Clients as well as speed up the process and improve the experience for the employees. Alternative Dispute Resolution (ADR) carve-outs have proven to significantly decrease the time-lines associated with the statutory workers' compensation system by: providing better care to injured workers; reduce time involved to resolve disputes over treating physicians; utilization review; and can all but eliminate lawyers in the system. Carve-outs allow employers and labor to create a separate track for resolving disputes through mandatory mediation and arbitration before claims can go to the Workers' Compensation Appeals Board. The parties are free to negotiate other terms of the program, such as agreed-upon panels of doctors and independent medical Examiners (IME) to prevent disputes before they start, as well as benefit enhancements that go beyond State-mandated minimums. AIMS encourages our qualified Clients to consider this cost saving program.

AIMS Rapid Referral Portal: AIMS has developed and utilizes a web-based communication platform that connects our claims staff with all recommended/allowable service providers. Through this process, we have the ability to monitor assignments to preferred providers that are identified and selected for our individual Clients. AIMS has researched and vetted service providers for quality and best-value for our Client and will make our recommendations known to the City. The service provider "panel" is pre-approved by our individual Clients. Any exceptions to appropriate assignments are managed on a case-by-case basis. Through this platform, we have the ability to track, manage, and run reports on service provider usage.

Maximum number of indemnity files: The targeted average indemnity caseload for a senior Claims Examiner is based on the requirements of our Client. If no specific caseload is specified, we target 150 indemnity claims per Claims Examiner, but acknowledge that the City has an indemnity cap of 125. On a monthly basis, we review Claims Examiner activity reports that capture all new claims and closing ratios. The Claim Supervisors consistently manage the Claims Examiner's caseloads to ensure caseload levels are managed based on our Client specific requirements. AIMS, as matter of practice, assigns Claims Examiners in one of two ways:

1. By claims frequency and Client request warrant, the account is assigned on a fully dedicated basis. In those instances the Claims Examiner(s), work on a single account only. The City currently has two dedicated Claims Examiners handling their open active indemnity files.
2. If volume does not warrant, Claims Examiners are assigned on a designated basis.

Focus on Service: We work in partnership with our Clients to achieve optimal results, consistent with fair compensation for material loss and humane, competent, compassionate care for injured employees. We have built our business, and a stellar reputation, on communication and partnership with our Clients. AIMS senior management takes an active role in supervision of our dedicated account teams to assure timely response, proactive claims management and consistent quality control.

Our goal is to customize our products and services to serve you best and to help you spend your money wisely**.**

Client Service: Our Clients are not just the employers, but also the employees who have sustained industrial injuries or illnesses while working within the course and scope of their employment. We focus on promptly providing these employees the benefits due to them and maintaining open and on-going communication with them during the course of their claims. Programs that provide this positive approach produce lower overall workers' compensation costs, including significantly reduced litigation expenditures.

Primary Service Office: The Company has extensive professional management, technical and support staff in multiple offices located throughout California and Hawaii. AIMS California offices are located in Santa Clarita, Sacramento, Pomona, Fresno and Concord.

We propose to continue to provide Claims Administration services to the City from our office in Sacramento.

AIMS Corporate Headquarters will continue to serve as the location providing loss data functions other than claims adjusting. The AIMS corporate headquarters is located at 10445 Old Placerville Road in Sacramento, CA 95827.

Please see Exhibits 1 - Organization Charts and Exhibit 2 – Legislative Advocate Report

C. Methodology Section

Provide a detailed description of the approach and methodology to be used to accomplish the Scope of Services of this RFP. The Methodology Section should include:

1) An implementation plan that describes in detail (i) the methods, including controls by which your firm manages projects of the type sought by this RFP; (ii) methodology for soliciting and documenting views of internal and external stakeholders; (iii) and any other project management or implementation strategies or techniques that the respondent intends to employ in carrying out the work

AIMS/AMC has extensive experience in implementing and transitioning workers' compensation and managed care programs from other industry administrators and managed care organizations. As City of Richmond is a current client, there would be no transition of data or transfer of files if the City continues their programs with AIMS/AMC.

2) Detailed description of efforts your firm will undertake to achieve client satisfaction and to satisfy the requirements of the "Scope of Services" section

AIMS is committed to achieving a high level of client satisfaction and to deliver all of the

requirements outlined in the "Scope of Services" section. To monitor this activity and to validate the program is on course, a survey is taken every year by the City of Richmond. The purpose of this event is to provide an opportunity for the City of express any concerns or issues with their program, the claims handling and/or their staffing. This "check-in" will occur more frequently if issues are identified that require follow-up. Once the survey is completed, the Client Services Department reports their findings back to Operations and Corporate Leadership on a monthly basis. The leadership Team addresses any weaknesses in our programs and documents the steps taken to make the necessary improvements.

3) Detailed project schedule, identifying all tasks and deliverables to be performed, durations for each task, and overall time of completion.

Although the City of Richmond would not require any transition if the award of contract remains with AIMS/AMC, we have attached a sample of our Transition Plan for review on the below noted exhibit.

4) Detailed description of specific tasks you will require from City staff. Explain what the respective roles of City staff and your staff would be to complete the tasks specified in the Scope of Services.

If a transition was required, AIMS would coordinate with the City on all meetings involving specific City Departments and the topic of discussion for the meeting. These meetings normally begin 60-days prior to the contract start date and are conducted every week until approximately 45-days post implementation

Please see Exhibits 3 – AIMS Transition/Implementation Plan and Exhibit 9 - Scope of Services Detail

D. Staffing

Describe proposed Project team organization, including identification and responsibilities of key personnel. Indicate role and responsibility of prime consultants and all sub-consultants. If applicable, indicate how local firms are being utilized to ensure a strong understanding of state and local laws, ordinances, regulations, policies, requirements, and permitting. Indicate the extent of the commitment of key personnel for the duration of the Project and furnish resumes of key personnel. Provide an indication of the staffing level for the Project. The City of Richmond's evaluation of the proposal will consider the proposer's entire team; therefore, no changes in the team composition will be allowed without prior written approval of the City of Richmond. Sub-consultant letters of

commitment are required and must be submitted with the proposal

Kim Silas, Claims Manager: Kim will continue to serve as the City's primary representative. Kim has worked in the California Workers' Compensation Industry since 1990 and prior to that she worked within the Insurance Industry. Kim has her Workers' Compensation Claims Professional (WCCP) and Workers' Compensation Claims Administration (WCCA) designations from the Insurance Education Association (IEA) and the Self-Insurance Plans Certificate to Administer Workers' Compensation Claims. Kim has been a Claims Supervisor since 2005 and Claims Manager since 2011.

AIMS Corporate Management Team

The AIMS corporate management team of professionals identified below has extensive claims management tenure. They understand the importance of monitoring each claim to see that every event that affects the outcome is recognized and appropriately managed. These individuals are involved from the onset at the proposal stage, through contracting, implementation, and for the life of the program. Their objective will be to facilitate a successful program for the City.

Dominic Russo, President & CEO: Dominic has served as President of AIMS since 1994. Under his leadership, AIMS has consistently met its corporate strategy to nurture long term relationships by providing our Clients with technically competent, experienced, and dedicated staff acting with integrity in all that we do. Prior to Mr. Russo's position as President & CEO, he has served in various industry positions of management from supervisor to Vice President in Southern California, Northern California, and Hawaii. Dominic achieved his Owner President Management Certification from the Harvard Business School.

Lynn Cavalcanti, Sr. Vice President Operations: Lynn has over 25 years of claims experience, all with public entities. Her role serves AIMS Clients by establishing critical service, program operations, and productivity criteria; benchmarking leading-edge practices; developing marketing channels; leading commitment to quality service; evaluating service results, and representing the company to major customers (making periodic visits, exploring specific needs, and resolving problems). She has a Master of Arts as well as a Juris Doctorate degree. Lynn joined the AIMS team in 2010.

Tricia Baker, Assistant Vice President, Operations*:* Tricia has over 27 years of workers' compensation claims experience with public entities and insurance. Tricia assists the Senior Vice president of Operations with Client relations issues, managing new Client implementations and transitions, identifying and coordinating training, maintaining appropriate controls, and ensuring AIMS delivers as promised. Tricia serves as the Transition Coordinator for new program implementations. Tricia joined the AIMS team in 2013.

Cheryl Agee, Vice President Workers' Compensation: Cheryl has thirty-plus years in the Workers' Compensation sector as an Examiner, Supervisor and twenty-one years as

a Claims Manager. She is responsible for the analysis of work performance against best practices, which includes compliance oversight, internal audits, and quality control. This includes the development and delivery of Workers' Compensation training programs such as ongoing technical training, standardized work flow processes. Cheryl is responsible for best practice implementation and revision, work measurement, management oversight practices and the development of performance standards at various levels. Cheryl also leads the company in interpreting and implementing new work flow processes following legislative enactment. Cheryl joined the AIMS team in 2005.

Rendell ("Ren") Johnson, Vice President Information Technology: Ren has held various positions in the information technology industry over the last 18 years, 15 years in leadership positions, including the last 8 years as Director of Information Technology in the workers' compensation industry. Ren has been making strategic technology decisions and providing state of the art solutions for pre-IPO, government, healthcare, workers' compensation, and enterprise environments. Ren will be overseeing the implementation from an IT perspective. He has studied in Business Administration with training and certifications in networking, security, and Microsoft technologies. Ren joined the AIMS team in 2010.

Kristina ("Tina") Patterson, Manager of Data Delivery Services: Tina has over 10 years workers' compensation claims experience. She is a state-certified self-insurance administrator, as well as Workers' Compensation Claims Administration. Tina oversees the ongoing claims system of the AIMS/AMC Data and how it interacts with various systems. Tina joined the AIMS team in 2016.

As the current incumbent, AIMS has established a staffing model that is responsive to the requirements of the City. This team consists of the following individuals:

- Experienced Manager: Kim Silas
- Dedicated Senior Claims Examiner: Tamala Palmer
- Dedicated Claims Examiner: Tamara Nolasco
- Future Medical Examiner: Nieves Sumpo
- Claims Assistant: Denise Ondo

Having an experienced team in place ensures consistency and continuity for the City, but most importantly to care for City's injured employees. This established team will maintain the program efficiencies without any disruption of a transferring of existing open claims.

As a matter of practice, AIMS designates and/or dedicates key personnel to an account and strives to maintain consistency of the assigned team for each of our valued Clients. If claims frequency and Client request warrant, the account is assigned on a fully dedicated basis. In those instances the Examiner(s), work on a single account only. If volume does not warrant, Examiners are assigned on a designated basis.

Please see Exhibits 1 - Organization Charts and Exhibit 4 - Team Resumes

Describe the experience of the proposer's Project team in detail, including the team's Project Manager, and other key staff members, on projects of similar size, capacity, and dollar value. For each similar project, include the client's name and correct telephone number. It is the City of Richmond's policy to interview proposers' references as well as references identified by the City of Richmond.

Please see above resumes and discussion on Corporate and Branch Office staffing to be assigned to the City of Richmond Account.

E. Qualifications

The information requested in this section should describe the qualifications of the firm, key staff and sub-contractors performing projects within the past five years that are similar in size and scope to demonstrate competence to perform these services. Information shall include:

1) Names of key staff that participated on named projects and their specific responsibilities with respect to this scope of service.

Please see above resumes and description of area of responsibility for both Corporate and Branch Office staffing who will be assigned to the City of Richmond Account.

Please see Exhibit 4 - Team Resumes

2) A summary of your firm's demonstrated capability, including length of time that your firm has provided the services being requested in this Request for Proposal.

As City of Richmond is an existing Client, AIMS has provided the services identified in this RFP for the past 10 years.

3) Provide at least three (3) references that received similar services from your firm. The City of Richmond reserves the right to contact any of the organizations or individuals listed. Information provided shall include:

a) Client Name and contact info

- Telephone & e-mail address
- Address

b) Description of services provided including contract amount

c) Project start and end dates

We are providing the requested Information on the below noted exhibit.

Please see Exhibit 5 – Client References

F. Cost Information

Provide the total direct and indirect costs to complete all tasks identified in the scope of services. Even if the method of payment to proposer will be fixed fee, a detailed cost breakdown shall be provided identifying: (1) the number of staff hours and hourly rates for each professional and administrative staff person who will be committed to this Project; (2) all other direct costs, such as materials and reproduction costs; and (3) sub-consultant services, if needed. These rates will also be used to negotiate rates for other projects (including optional tasks) that may be assigned. No additional funds will be paid above and beyond the original quote given by the selected Vendor.

Proposers will be paid at the same rates set forth in their cost proposal unless further negotiated in writing and agreed to by the City of Richmond.

AIMS is proposing a Flat Annual Fee for the Third Party Claims Administration Services part of this RFP. The Cost Proposal document outlines which costs are included in this fee. Managed Care Services Fees are outlined following the TPA Fees.

Please see Exhibit 6 – Cost Proposal

G. Value Added Services

Please provide any additional services of benefit not specifically required herein, which the Offeror offers to provide.

All services offered are identified in the Cost Proposal Document.

H. Contractor Assignment of Sub-Contract

The resulting contract shall not be assigned, transferred, or sublet, in whole or in part, without the prior written approval of the City of Richmond. If Offerors intend to subcontract any portion of the resulting contract, they must describe their process for selecting such subcontractor(s) and the quality control measures that the Offeror will employ to ensure that any subcontractor complies with the provisions of Offeror's contract with the City.

AIMS/AMC agrees to this requirement.

I. Previous Contracts with the City of Richmond

The proposer shall submit a list which indicates all prime contracts and/or amendments awarded to the proposer by the City of Richmond for the last three (3) years. The list shall include a short description of the Project, the Project scope of work, award date, completion date, name of City of Richmond's assigned Project Manager, and contract value.

AIMS has been providing services to the City of Richmond as a Third-Party administrator for its Workers' Compensation Program for the past 10 years.

J. Exceptions to this Request for Proposals

The proposer shall state whether or not it takes exception(s) to this RFP, including but not limited to the City of Richmond's Standard Services Agreement – RFP. If the proposer does take exception(s) to any portion of the RFP or contract, the specific portion to which exception(s) is taken must be identified by section number and explained. Requests for changes or additions to sections of City of Richmond's Standard Services Agreement must be shown by requesting deletion of specific words and/or by providing new requested contract language. Requests for complete replacement of the City of Richmond's Standard Services Agreement for another contract will not be granted. Failure to make exceptions to the RFP or Standard Services Agreement within the proposal will be deemed a waiver of any objection. Exceptions will be considered during the proposal evaluation process.

AIMS/AMC does not take exception to any portion and/or requirement in the RFP.

K. Statement of Impartiality and Disclosure

The nature of this Project requires an impartial unbiased approach on the part of the proposer's team. This proposal shall include a statement declaring that the proposer's and sub-consultants are not currently, and will not, during the performance of these services, participate in any other similar work involving a third-party with interests currently in conflict or likely to be in conflict with City of Richmond's interests. Additionally, proposer is required to disclose any pending or active investigations or litigation that may affect the reputation or ability of the proposer to carry out the Project.

AIMS/AMC agrees to this requirement.

Proposer Qualifications

AIMS has provided a detailed description of the efforts we undertake to achieve Client satisfaction throughout our proposal and we have provided specific response to each

requirement. Also, AIMS has carefully reviewed the Scope of Services, the Proposer Qualifications and Attachment III - TPA Performance Expectations Sections of this RFP and will comply with ALL requirements, we have provided separate exhibits for these sections.

Please see Exhibits - 6 Cost Proposal, Exhibit - 9 Scope of Services Detail and Exhibit - 15 Proposer Qualifications.

RFP Attachments
And Required Forms

CITY OF RICHMOND

Sanctuary City Compliance Statement

The undersigned, an authorized agent of **Acclamation Insurance Management Services, Inc. (AIMS)** (hereafter "Contractor"), has had an opportunity to review the requirements of City of Richmond Ordinance 12-18 (hereafter "Sanctuary City Contracting Ordinance" or "SCCO"). Contractor understands and agrees that the City may choose with whom it will maintain business relations and may refrain from contracting with any person or entity that provides Data Broker or Extreme Vetting services to the U.S. Immigration and Customs Enforcement Division of the United States Department of Homeland Security ("ICE"). Contractor understands the meaning of the following terms used in the SCCO:

a. "Data Broker" means either of the following:

i. The collection of information, including personal information about consumers, from a wide variety of sources for the purposes of reselling such information to their customers, which include both private-sector business and government agencies;

ii. The aggregation of data that was collected for another purpose from that for which it is ultimately used.

b. "Extreme Vetting" means data mining, threat modeling, predictive risk analysis, or other similar services."

Contractor understands that it is not eligible to receive or retain a City contract if at the time the Contract is executed, or at any time during the term of the Contract, it provides Data Broker or Extreme Vetting services to ICE.

Contractor further understands and agrees that Contractor's failure to comply with the SCCO shall constitute a material default of the Contract and the City Manager may terminate the Contract and bar Contractor from bidding on future contracts with the City for five (5) years from the effective date of the contract termination.

By executing this Statement, Contractor certifies that it complies with the requirements of the SCCO and that if at any time during the term of the Contract it ceases to comply, Contractor will promptly notify the City Manager in writing. Any person or entity who knowingly or willingly supplies false information in violation of the SCCO shall be guilty of a misdemeanor and subject to a $1,000 fine.

Based on the foregoing, the undersigned declares under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed this 22nd day of March, 2022, at Sacramento, California.

Printed Name: Dominic Russo **Title:** President & CEO AIMS, /AMC

Signed:  **Date:** March 22, 2022

Business Entity: **Acclamation Insurance Management Services, Inc. (AIMS)**

FINANCE DEPARTMENT

ADDENDUM NO. 2

March 15, 2022

Third Party Workers' Compensation Claims Administration and Managed Care Services

This Addendum shall be considered as a part of the RFQ documents for the subject professional services as though it had been issued at the same time and shall be incorporated integrally therewith.

The revised deadline for submission of Proposals is Tuesday, March 22, 2022 at 5:00PM.

If you have any questions, please contact me at (510) 620-6732.

Patrick McKenzie

PATRICK MCKENZIE
BUYER II
CITY OF RICHMOND

DATE: 3/15/22

450 Civic Center Plaza, Richmond, CA 94804-1630
Telephone: (510) 620-6740 Fax: (510) 620-6522 www.ci.richmond.ca.us

EXHIBITS

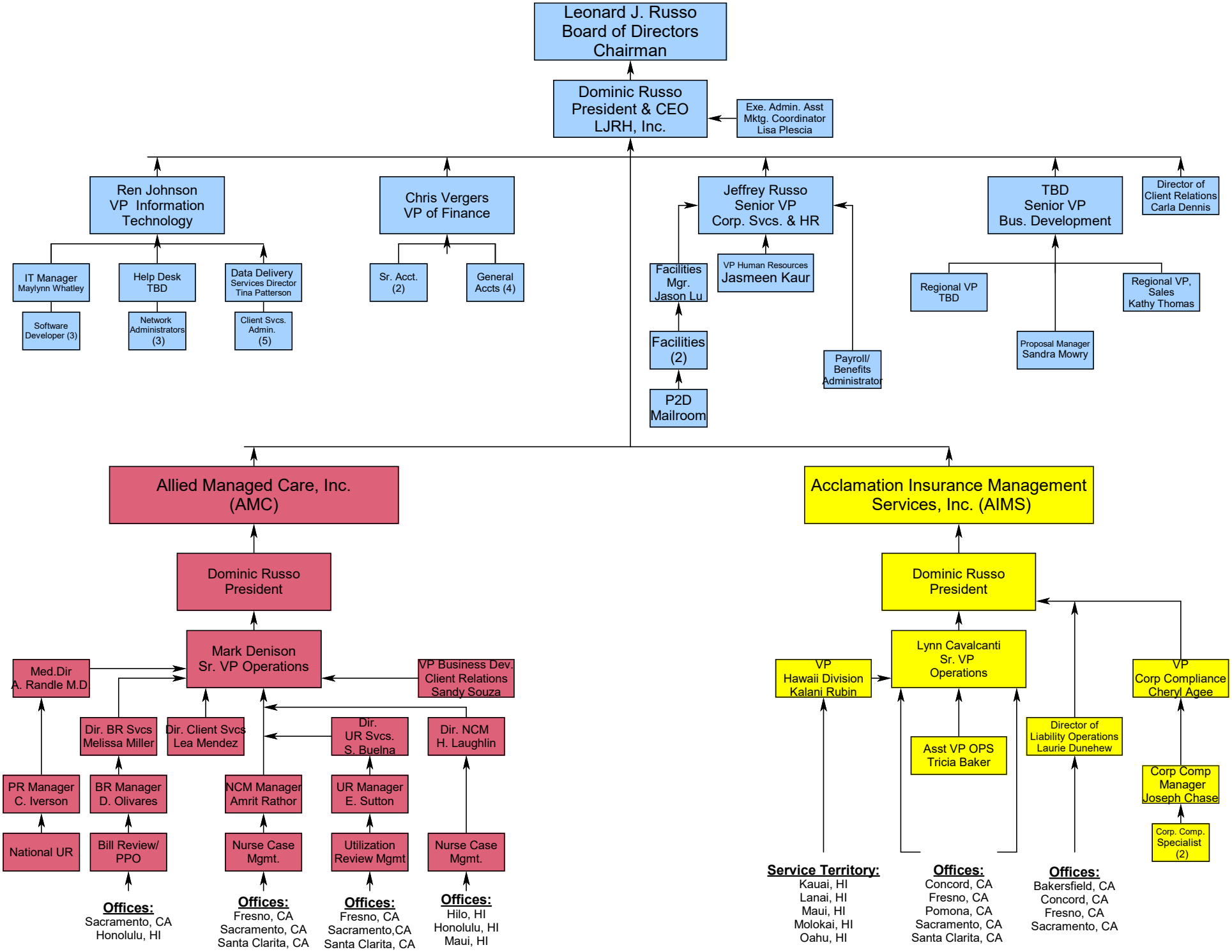
EXHIBIT 1 –
Organizational Charts for
AIMS & AMC

ACCLAMATION INSURANCE MANAGEMENT SERVICES

Organizational Charts

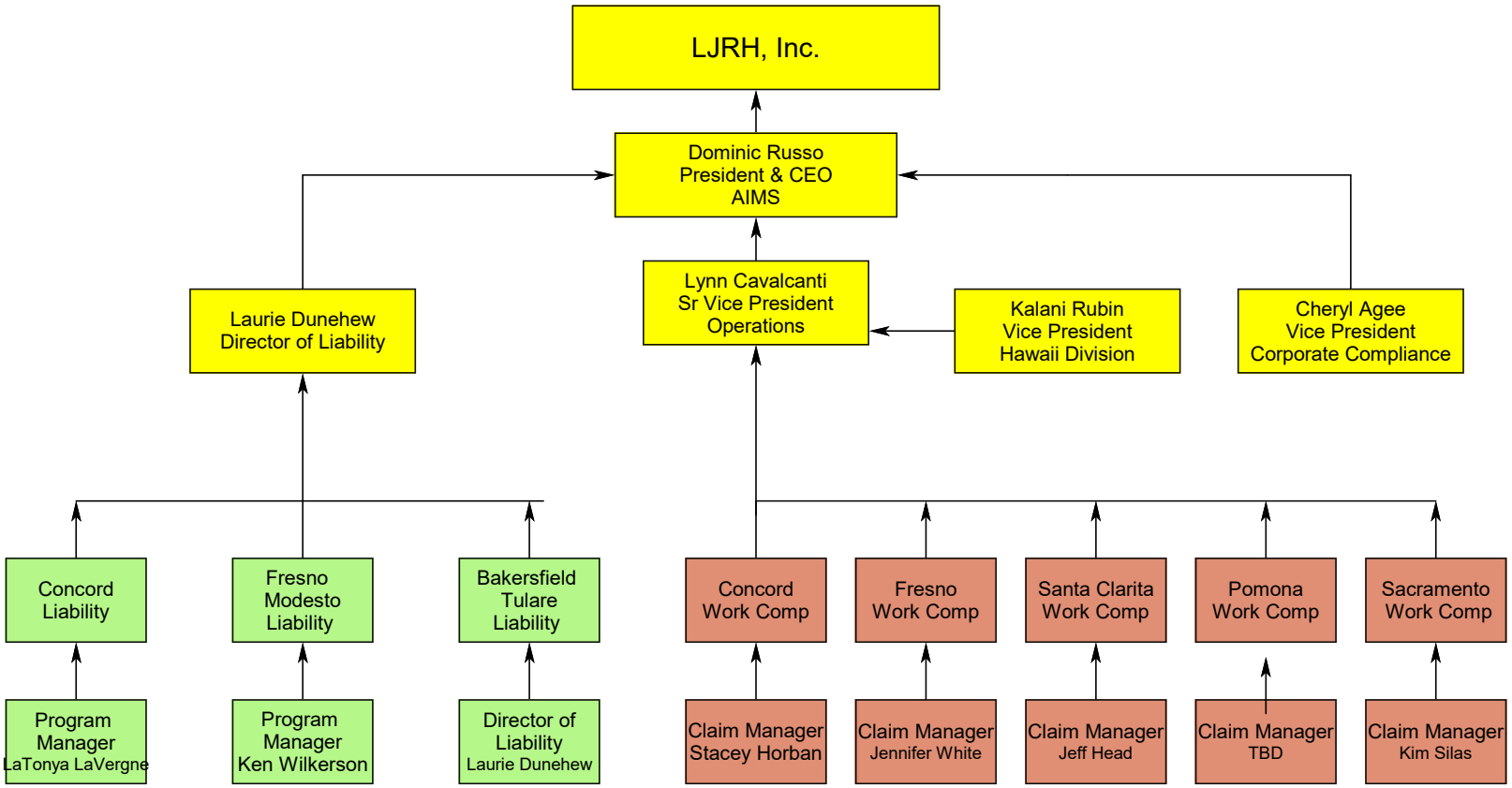
Attachment I

LJRH, Inc. Organization Chart



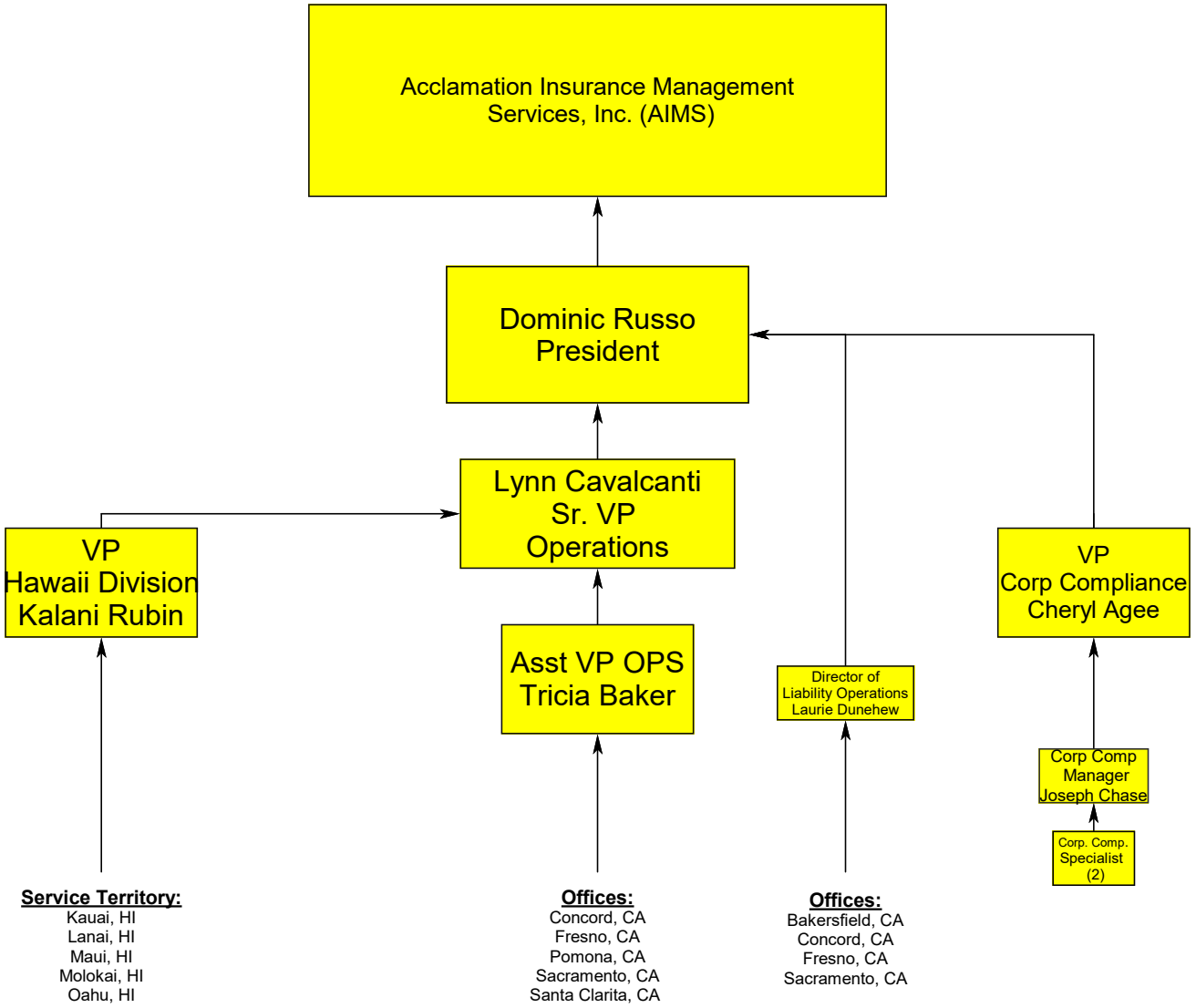
ACCLAMATION INSURANCE MANAGEMENT SERVICES

Acclamation Insurance Management Services, Inc. (AIMS)
California Third Party Administration Division (TPA)
Organizational Chart



ACCLAMATION INSURANCE MANAGEMENT SERVICES

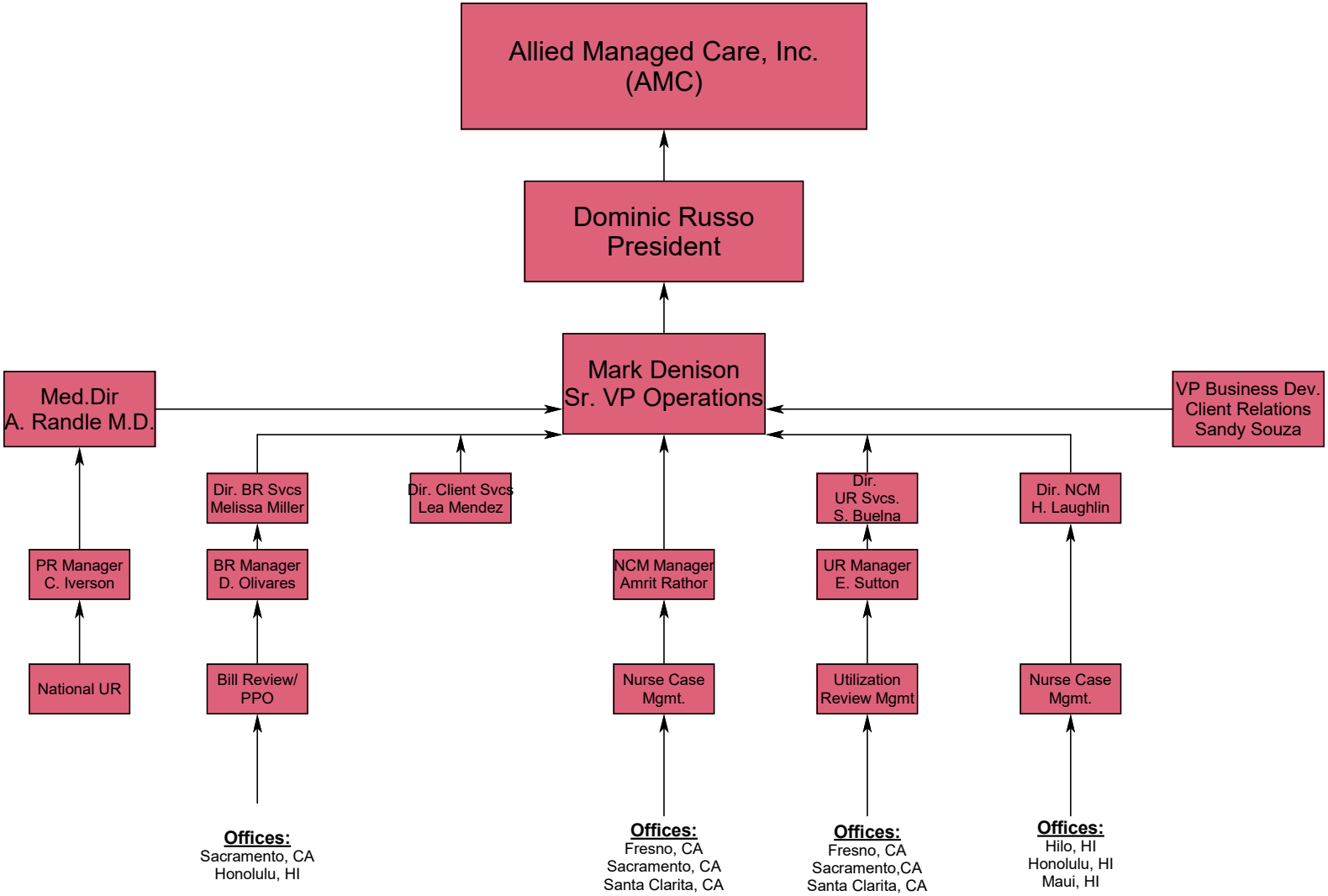
Attachment I



ALLIED MANAGED CARE INCORPORATED

Organizational Charts

Allied Managed Care Inc. (AMC)
Organizational Chart



Allied Managed Care Inc.
Utilization Review

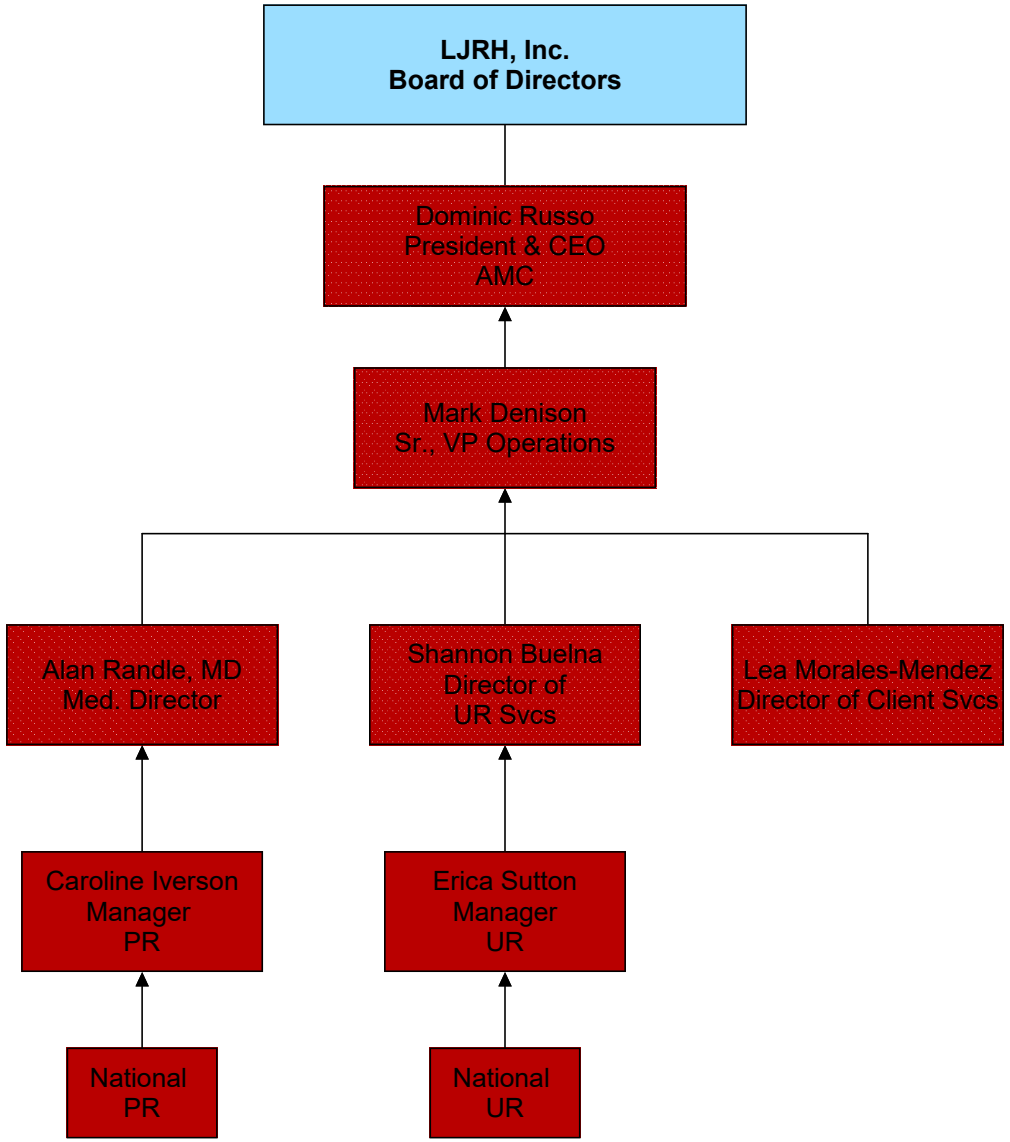


EXHIBIT 2 –
Legislative Advocate Report

Philip M. Vermeulen
GOVERNMENTAL RELATIONS

3457 Castle Creek Court Roseville, CA 95661 ● PH (916) 784-7055 ● Fax (916) 784-2852 ● Web www.pvgov.com

REPORT ON THE FINAL ACTIVITIES OF THE CALIFORNIA STATE LEGISLATURE

FOR THE YEAR 2021

PRESENTED TO: AIMS & AMC

BY: PHILIP M. VERMEULEN,
LEGISLATIVE ADVOCATE
October, 2021

"In a time when the state and country are more divided than ever, this legislative session reminds us what we can accomplish together. I am thankful for our partners in the state Legislature who furthered our efforts to tackle the state's most persistent challenges – together, we took action to address those challenges head-on, implementing historic legislation and the California Comeback Plan to hit fast forward on our state's recovery," ***Governor Gavin Newsom said in announcing his final bill signings. He went on to say****: "What we're doing here in California is unprecedented in both nature and scale. We will come back from this pandemic stronger than ever before."*

The commencement of the new, two-year legislative session back in January saw the Democrats with their strongest super majorities yet. Currently in the Assembly there are 60 Democrats, 19 Republicans and 1 Independent which constitutes a ¾ super majority; while in the Senate the Democrats hold 31 of the 40 seats which constitutes a 78% super majority. Coupled with this is the fact that all executive branch members (Governor, Lt Governor, Treasurer, Controller, Secretary of State and Insurance Commissioner) are held by Democrats as well.

Armed with these numbers, and a legislature that grows more 'Progressive' with each election cycle, this session's legislative agenda continued moving to the left. For perspective, there were a total of 2776 bills introduced, of which 836 were sent to the governor. He ultimately signed 770 and vetoed 66. This is a veto ratio of 7.89% for his third year in office. The number of vetoes for 2021 is the ninth lowest of all the years that have been tracked by Capitol staff since 1967.

The 'New' Form of Participatory Government

It was an interesting year in myriad ways. Simply, however, COVID-19 framed the session. It meant a continuation of 2020's legislative COVID policies and protocols that severely limited the interaction of the legislature with both the public and members of the 3rd house (lobbyists). While hearings continued to be held, there were crowd limits both in terms of entering the Capitol as well as entering the actual hearing rooms.

This had a serious effect on being 'hands on' with both the legislative staff and the members. Indeed, since the 'essence of lobbying is becoming as close and personal with both', this created a major barrier for everyone within the 3rd house (lobbyists) and members of the public.

Business Coalitions the New Norm

To counter both the limited access within the Capitol during these COVID times, coupled with an ever-more left-leaning legislature (**with the unions 'driving the boat'**), the old political phrase "strength in numbers" took on a whole new meaning. Employer coalitions have become the political tool that has proven time and again to 'herd the disparate cats' of employers under one roof to coordinate our efforts. While we didn't kill all of the 'bad' bills, we killed most and we were able to obtain significant amendments for most of the remaining ones that ultimately became law. **I will be discussing specific bills in more detail later in this report.**

Effects of COVID-19 on Public Policy

As I previously discussed, much of the 2021 session revolved around COVID-19 in one form or another. From the attempted recall of Governor Newsom, the many billions of dollars received and spent in federal pandemic aid, to the 'buckets' of money spent on an array of new and expanded public services, all can be attributed to COVID-19. It rallied the Progressives to justify spending on health care, social services, public schools, early childhood education, and increasing personal incomes of the poor which the leadership argued made California the national leader in advancing the European-style "social democracy" model that the Democrats' left wing wants the federal government to embrace.

Before this year's session began, for instance, 94% of Californians had some form of medical care coverage, thanks to Obamacare and a sharp expansion of the state's Medi-Cal program for the poor to more than a third of the state's population. This year's additions push California very close to universal coverage, a long-sought goal of those on the left and Newsom's oft-expressed ambition.

The leftward tilt of the session is also evident in other ways that do not spend money, such as making ethnic studies a requirement for high school education, banning gasoline-powered lawn equipment, imposing new restrictions on guns, and compelling department stores to have gender-neutral toy and child care departments.

The Legislature and Newsom also continued to move the state's criminal justice system leftward, reducing punishment for some crimes and cracking down on police officers who misbehave by lifting the licenses, called "certifications," they need to be employed.

There's every reason to expect that Newsom and the Legislature will continue to paddle California's political canoe to the left. Certainly, with regards to this session, any paddling to the right that Newsom did by vetoing bills that our business coalition opposed was **NOT** due to the ever-dwindling number of Republicans in the Legislature, but instead to the power that was comprised in the makeup of the members of the coalitions (including us, of course!) and possibly

due to the 'scare' of the recall and the realization that Newsom will face another election next November (2022). I should also mention that in years past the Republicans' 'clout' came from both working closely with, and literally relying upon, the influence of Democratic moderates; but the 'mod's' numbers and power are also waning badly. The only question is whether the economy will continue to churn out enough money to pay for the new benefits without tax increases!

About Gavin

NEWSOM'S LOFTY PROMISES: It's an enduring source of frustration with Gov. Gavin Newsom's leadership: the loftiness of his claims can outrun the reality.

Newsom is not shy about trumpeting his moves to make California a national leader on lodestar Progressive issues**.** He's fond of calling the "nation-state" he leads "America's next coming attraction", and he often proclaims he's ensuring the Golden State continues to set the pace on the environment, family welfare, coronavirus management and other issues.

I've heard it from many within 'The Building', who are his fellow Democrats and liberal interest groups, that contrary to his conservative foes who accuse Newsom of authoritarian overreach, these detractors tend to fault Newsom for making big promises that turn out, on closer inspection, to be not quite so consequential. It's often a matter of attenuated scope or of delayed implementation. He generates national media plaudits for the broad strokes but may offer few details on how to actually get there.

That's not to say the governor's allies are abandoning or renouncing him — you can see that in voters repudiating the recall by a 22-point margin that's virtually identical to Newsom's landslide 2018 victory. Incremental progress, or executive actions that move California in a desired direction, still win praise from Progressives. Newsom has signed numerous consequential bills and an enormous budget stocked with policies and spending items that are popular among his supporters.

But there's still a sense that the governor likes to announce now and work out the nuances later. A few examples-- a school vaccine mandate won't take effect imminently and just kicks a fight over contentious exemption loopholes to the Legislature. Environmentalists worry his orders to move away from fossil fuels will take effect too slowly and without enough sweep. Expanded family leave efforts and a long-sought move to single-payer health care aren't quite matching campaign promises.

With the 2022 election on the horizon, it will be 'interesting' (and scary for the business community) to see how Gavin responds to the aforementioned during the 2022 legislative session. Hold on to your hats!

Workers' Comp Bills in 2021

The power of the public worker unions (the 500-pound gorilla) appeared daunting by mid-March after the bill introduction deadline had passed and we saw the plethora of comp bills and their key amendments they had sponsored which were now in print. Facing myriad union-sponsored 'bad' bills authored and moving through a 'Progressive' legislature, whose membership was elected in large part by these unions, was nerve wracking at best! Besides the unions, the California Society of Industrial Medicine (CSIMS) was back at it again as were the Applicant Attorneys!

With 7 presumptions bills being driven by the unions set to be heard, I was skeptical that our workers' comp coalitions would have the 'juice' to stop the onslaught. Amazingly, one by one, the bills dropped by the wayside as did many of the other bad comp bills. Then, during the last two- weeks of the session, the final two presumption bills, AB 334 (Mullin) and SB 284 (Stern) were placed on the inactive file making them both two-year bills!!!

The first of the two to be pulled was SB 284 in late August, followed by AB 334 on the last day of the session. Since both of these measures were 'sailing' and certain to be sent to the governor, what could possibly have stopped them in their tracks?

My first call was to my 'key' insider who has worked closely on workers' comp matters with the unions and other stakeholders for many years. My suspensions were confirmed. To wit:

It's hard to believe, but 2022 marks the 10th anniversary of the passage of our last major worker comp reform bill, SB 863 (de Leon). And, I've learned there have been some 'behind the scenes' discussions about a major workers' comp reform package next year with some key folks in the industry (and in government leadership, too).

'Word' has it that benefit increases are being discussed as well as other 'tweaks' to offset these increases. So too, there are likely efforts in this process by the unions to push for a much larger presumption package that would be much more inclusive of different unions and their members!

Suddenly then, if presumptions are in the mix of a union-driven reform package for next year, passing AB 334 or SB 284 this year could have resulted in the life guards and firefighters possibly losing out to an even better 'deal' next year. By letting both become two-year bills, the

sponsors can do a 'wait and see' which allows them the leverage to either join on to a 'better deal' or, if not, then allows them to obtain the signature of the governor next year.

At this juncture, everything is in the 'chatter' stage and I've now been asked to become involved in the ongoing discussions during the legislative interim. Stay tuned.

From the start of the session when there were 18 comp bills staring at us, only 3 bills ultimately were signed by the governor, two of which were committee clean-up bills and one 'bad' disability presumption bill!

Following are the comp bills, their sponsor and their status:

Listing of Workers' Comp Bills Introduced in 2021

AB 334 (Mullin D) Workers' compensation: skin cancer. Presumption

Sponsored by: Game Wardens Union, et al

Status – 2-Year Bill

Current law provides, among other things, that skin cancer developing in active lifeguards is presumed to arise out of and in the course of employment, unless the presumption is rebutted. This bill would expand the scope of those provisions to certain peace officers of the Department of Fish and Wildlife and the Department of Parks and Recreation.

Position: Oppose

AB 399 (Salas D) Workers' compensation.

Sponsored by: CSIMS

Status – 2-Year Bill

Would impose new requirements on a medical provider network, including, among other things, requiring a participating provider to participate at each location at which they treat patients for 8 or more hours per week, on a monthly average. The bill would also prohibit authorizations or certifications issued by a carrier, claims administrator, medical provider network, or utilization review entity from providing instruction or imposing a requirement as to the location of where a treatment takes place or the provider who will perform the treatment. The bill would prohibit a vendor, provider, or group within the medical provider from being preferentially cited on an authorization or certification and would require the administrative director to impose a fine of $10,000 per authorization or certification that preferentially directs care within a medical provider network.

Position: Active Oppose

AB 404 (Salas D) Workers' compensation: medical-legal expenses: fee schedule.

Sponsored by: CSIMS

Status – 2-Year Bill

Under current law, fees for medical-legal evaluations are charged at a rate not to exceed a physician's regular fee, or the fee schedule set by the administrative director of the Division of Workers' Compensation, whichever is lower. Current law requires that the schedule set fees for procedures according to relative values and a conversion factor, allowing for modifiers, as specified. Current law requires the medical-legal fee schedule to be revised at the same time the fee schedule for medical treatment is revised. This bill would require that the medical-legal fee schedule be reviewed every 2 years, and updated, if necessary, to increase the conversion factor by the percentage increase in the most recent federal Medicare Economic Index.

Position: Watch

AB 415 (Rivas, Robert D) Employment: workers' compensation. Presumption

Sponsored by: SEIU, et. al

Status – 2-Year Bill

This bill would define "injury," for certain employees of a city, county, city and county, district, or other municipal corporation or political subdivision regularly exposed to active fires or health hazards directly resulting from firefighting operations, to include cancer that develops or manifests during a period in which the individual demonstrates that they were exposed to a known carcinogen while in the employment of the city, county, city and county, district, or other municipal corporation or political subdivision. The bill would establish a presumption that the cancer in those cases arose out of, and in the course of, employment, unless the presumption is controverted by evidence that the primary site of the cancer has been established and that the carcinogen to which the person has demonstrated exposure is not reasonably linked to the disabling cancer.

Position: Active Oppose

AB 772 (Ramos D) Workers' compensation: domestic terrorism.

Sponsored by: Assemblyman Ramos who previously served on Bd of Supes in San Bernardino when terrorist struck

Status – 2-Year Bill

This bill would clarify that an employer is not limited in its ability to insure against an act of

domestic terrorism or to provide benefits in excess of those required by existing law following an act of terrorism.

Position: Watch

AB 845 (Rodriguez D) Disability retirement: COVID-19: presumption.

Sponsored by: Service Employee International Union, et. al

Status: Chapter #122 of 2021 Statutes

Current law prescribes various requirements for the organization and administration of public retirement systems, which typically provide pension, disability, and death benefits to their members. Current law provides that participants in certain membership categories may be entitled to special benefits if death or disability arises in the course of employment. The California Public Employees' Pension Reform Act of 2013 (PEPRA) generally requires a public retirement system, as defined, to modify its plan or plans to comply with that act and establishes, among other things, limits on defined benefit formulas and caps on pensionable compensation. This bill, until January 1, 2023, would create a presumption, applicable to the retirement systems that PEPRA regulates and to specified members in those systems, that would be applied to disability retirements on the basis, in whole or in part, of a COVID-19-related illness. In this circumstance, the bill would require that it be presumed the disability arose out of, or in the course of, the member's employment. The bill would authorize the presumption to be rebutted by evidence to the contrary, but unless controverted, the applicable governing board of a public retirement system would be required to find in accordance with the presumption.

Position: Active Oppose

AB 872 (Wood D) Leave of absence: firefighters.

Sponsored by: Fire Fighters

Status Vetoed

Under current law, workers' compensation benefits, including salary paid in lieu of disability payments, is not taxable income. Current law also provides for enhanced industrial leave benefits for specified state employees, including members of State Bargaining Unit 8, such as 52 weeks of salary less specified tax and retirement contributions. This bill would make those enhanced industrial disability leave benefits for specified state employees employed by the Department of Forestry and Fire Protection applicable only to injuries that occur prior to January 1, 2022. The bill would instead, for injuries occurring on or after January 1, 2022, make specified benefits, such as one year of salary in lieu of disability payments, available to all rank-and-file and supervisory fire fighters and members of State Bargaining Unit 8 engaged in active fire suppression or prevention employed by the Department of Forestry and Fire Protection and specified seasonal employees whose principal duties include active fire suppression or prevention services. These benefits would be subject to limitations, as specified.

Position: Oppose

AB 991 (Ward D) Workers' compensation: presumed injuries.

Presumption

Sponsored by: Lifeguards, et. al.

Status – 2-Year Bill

This bill would expand presumptions for hernia, pneumonia, heart trouble, cancer, tuberculosis, bloodborne infectious disease, methicillin-resistant Staphylococcus aureus skin infection, and meningitis-related illnesses and injuries to a lifeguard employed on a year-round, full-time basis by the City of San Diego. The bill would increase the period of time after termination of employment that a lifeguard employed on a year-round, full-time basis by the City of San Diego can file a claim for skin cancer. The bill would expand the presumptions for illness or injury related to post-traumatic stress disorder or exposure to biochemical substances, as defined, to a lifeguard employed by the City of San Diego Fire-Rescue Department.

Position: Active Oppose

AB 1148 (Daly D) Workers' compensation insurance reporting.

Sponsored by: Assembly Insurance Committee

Status – 2-Year Bill

Current law requires a licensed rating organization to establish and maintain an internet website to assist a person in determining if an employer is insured for workers' compensation. Current law required the Insurance Commissioner to review and evaluate the establishment and operation of the internet website, assess whether the internet website is achieving its purpose, and report the findings to specified legislative and executive entities no later than July 1, 2013. This bill would require the commissioner to review and evaluate the operation of a licensed rating organization's internet website and assess whether the internet website is achieving its purpose at least every 5 years, beginning in 2023.

Position: Watch

AB 1465 (Reyes D) Workers' compensation: medical provider networks study.

Sponsored by: Assembly Member Reyes

Status – 2-Year Bill

Would require the Commission on Health and Safety and Workers' Compensation, on or before January 1, 2023, to submit a study to the Legislature, the committees of the Senate and Assembly with jurisdiction over workers' compensation, and the Division of Workers' Compensation on

delays and access to care issues in medical provider networks. The bill would require the study to compare specified data for injury claims in which a worker was treated by a medical provider network to that data for injury claims in which a worker was treated by a provider who is not part of a medical provider network.

Position: Active Oppose

AB 1511 (Committee on Insurance) - Insurance: omnibus.

Sponsored by: Assembly Insurance Committee

Status: Chapter #627 of 2021 Statutes

Current law generally regulates insurance and creates the Department of Insurance, headed by the Insurance Commissioner. Current law requires all public records of the department and the commissioner that are subject to disclosure under the California Public Records Act to be available for inspection and copying, as specified, at the offices of the department in the San Francisco Bay area, in the City of Los Angeles, and in the City of Sacramento. This bill would eliminate the reference to an office in the San Francisco Bay area and instead refer to the department's offices in the City of Oakland, the City of Los Angeles, and the City of Sacramento.

Position: Watch

AB 1541 (Committee on Insurance) - Insurance: Guarantee Association.

Sponsored by: Assembly Insurance Committee

Status: Chapter #305 of 2021 Statutes

Current law establishes the California Insurance Guarantee Association (CIGA) to provide coverage against losses arising from the failure of an insolvent property, casualty, or workers' compensation insurer to discharge its obligations under its insurance policies. Current law gives CIGA the ability to request the issuance of bonds by the California Infrastructure and Economic Development Bank to more expeditiously and effectively provide for the payment of covered claims arising from the insolvencies of insurance companies providing workers' compensation insurance. Current law requires that any bonds that provide funds for covered claim obligations for workers' compensation claims be issued, as specified, prior to January 1, 2023. This bill would extend the date for bonds to be issued to provide funds for covered claim obligations for workers' compensation claims, as specified, to January 1, 2026.

Position: Watch

AB 1562 (Committee on Insurance) Workers' compensation: reports.

Sponsored by: Assembly Insurance Committee

Status – 2-Year Bill

Current law requires the Commission on Health and Safety and Workers' Compensation to issue an annual report on the state of the workers' compensation system, including recommendations for modifications that would improve the operation of the system. Current law requires the report to be made available to the Governor, the Legislature, and the public on request. Current law also requires the commission to periodically issue a report and recommendations on the improvement and simplification of notices required to be provided by insurers and self-insured employers, as it deems necessary. This bill would require the annual report on the workers' compensation system to be made available on the commission's internet website and to specifically be made available to the Assembly Committee on Insurance and the Senate Committee on Labor, Public Employment and Retirement rather than to the Legislature generally.

Position: Watch

SB 213 (Cortese D) Workers' compensation: hospital employees.

Presumption

Sponsor: Nurses Union

Status: 2-year bill

Current law, until January 1, 2023, creates a rebuttable presumption of injury for various employees, including an employee who works at a health facility, as defined, to include an illness or death resulting from COVID-19, if specified circumstances apply. This bill would define "injury," for a hospital employee who provides direct patient care in an acute care hospital, to include infectious diseases, cancer, musculoskeletal injuries, post-traumatic stress disorder, and respiratory diseases. The bill would create rebuttable presumptions that these injuries that develop or manifest in a hospital employee who provides direct patient care in an acute care hospital arose out of and in the course of the employment. The bill would extend these presumptions for specified time periods after the hospital employee's termination of employment. Beginning January 1, 2023, the bill would include COVID-19 in the definitions of infectious and respiratory diseases.

Position: Active Oppose

SB 216 (Dodd D) Contractors: workers' compensation insurance: mandatory coverage.

Sponsor: Contractors License Board

Status: 2-year bill

This bill is something I have pushed the construction industry (whom I have represented for over 40 years) and the Contractors State License Board to mandate for years. There is simply too much cheating and lying by many contractors that is wasting too much time CSLB enforcement time. Since most contractors require the need for employees, mandating workers comp for all contractors is long overdue! This bill will pass next year!

Would, until January 1, 2025, would require concrete contractors holding a C-8 license, warm-air heating, ventilation and air-conditioning (HVAC) contractors holding a C-20 license, or tree service contractors holding a D-49 license to also obtain and maintain workers' compensation insurance even if that contractor has no employees. The bill, as of January 1, 2025, would require all licensed contractors or applicants for licensure to obtain and maintain workers' compensation insurance even if that contractor has no employees and would also prohibit the filing of a certificate of exemption.

Position: Support

SB 284 (Stern D) Workers' compensation: firefighters and peace officers: post-traumatic stress. Presumption

Sponsor: Firefighters, et. al.

Status: 2-Year Bill

Current law, under the workers' compensation system, provides, only until January 1, 2025, that, for certain state and local firefighting personnel and peace officers, the term "injury" includes post-traumatic stress that develops or manifests during a period in which the injured person is in the service of the department or unit, but applies only to injuries occurring on or after January 1, 2020. Existing law requires the compensation awarded pursuant to this provision to include full hospital, surgical, medical treatment, disability indemnity, and death benefits. This bill would make that provision applicable to active firefighting members of the State Department of State Hospitals, the State Department of Developmental Services, the Military Department, and the Department of Veterans Affairs, and to additional peace officers, including security officers of the Department of Justice when performing assigned duties as security officers and the officers of a state hospital under the jurisdiction of the State Department of State Hospitals or the State Department of Developmental Services, among other officers.

Position: Active Oppose

SB 335 (Cortese D) Workers' compensation: liability. Presumption

Sponsor: Firefighters, et. al.

Status: 2-Year bill

Current law prohibits a claim for workers' compensation from being maintained unless within 30 days after the occurrence of the injury, the injured person, or in case of the death, a dependent, or someone on the injured person's or dependent's behalf, serves notice of the injury upon the employer. Current law also requires an injured employee, or in the case of death, a dependent, or an agent of the employee or dependent, to file a claim form with the employer. Under current law, except for specified injuries, if liability is not rejected within 90 days after the date the claim form is filed with the employer, the injury is presumed compensable and the presumption is rebuttable only by evidence discovered subsequent to the 90-day period. This bill would reduce those 90-day time periods to 45 days and, for certain injuries or illnesses, including hernia, heart trouble, pneumonia, or tuberculosis, among others, sustained in the course of employment of a

specified member of law enforcement or a specified first responder, would reduce those time periods to 30 days.

Position: Active Oppose

SB 788 (Bradford D) Workers' compensation: risk factors.

Sponsors: Firefighters and Applicant Attorneys

Status: Vetoed

Current law establishes a workers' compensation system, administered by the administrative director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of employment. Current law requires a physician who prepares a report addressing the issue of permanent disability due to an industrial injury to address the cause of the permanent disability in the report, including what approximate percentage of the permanent disability was caused by other factors before and after the industrial injury, if the physician is able to make an apportionment determination. This bill would prohibit consideration of race, religious creed, color, national origin, gender, marital status, sex, sexual identity, or sexual orientation to determine the approximate percentage of the permanent disability caused by other factors. The bill would also express the Legislature's intent to eliminate bias and discrimination in the workers' compensation system.

New 2022 California Employment Laws

Most of the new employment laws signed by the governor this session had the same genesis as workers' comp, sponsored by the public worker unions (with strong support from the Building Trades and other private sector unions). Besides their intentions of furthering the rights and abilities of their union members, much of their ulterior motives are to 'level the playing field' against the non-union employers and their employees and to create new laws whose effects will 'spill-over' to the government sector.

Some statistics to put things into perspective pertaining to unions:

Over 200,000 people work for a State of California department or agency (other than a university). More than **80%** of these employees are represented by one of the state's 21 bargaining units in the collective bargaining process.

On the other hand, approximately 16% of the private sector workforce is unionized. This number continues to drop each year; hence, some of the motivation for the unions to push issues that will not only 'level the field' but also entice the non-union to organize, to be part of 'the brethren', and create further strength in numbers.

New Employee Laws YOU Need to Know are 'coming down the pike:'

Unless so noted, all new laws will take effect on January 1, 2022.

Safety and Wage Enforcement and Penalties

SB 606 Gonzalez (Chapter 336) On September 27, Governor Newsom signed Senate Bill 606, significantly expanding the California Division of Occupational Safety and Health's (Cal/OSHA) enforcement authority. SB 606 increases potential exposure for employers with multiple worksites in the state, requires Cal/OSHA to issue "egregious violations" in certain circumstances, increase the potential monetary fines associated with citations, and expands Cal/OSHA's authority to issue subpoenas and seek injunctions and temporary restraining orders. The law becomes effective January 1, 2022, so employers should use the remaining months of 2021 to identify and close any compliance gaps to reduce the risk of receiving an enterprise-wide violation or an egregious violation. The following analysis comes from the **National Law Review:**

Enterprise-Wide Violations

For employers with multiple worksites, SB 606 creates a rebuttable presumption that a violation is "enterprise-wide" when either of the following factors is met:

1. A written policy or procedure violates a Cal/OSHA safety standard, rule, order, or regulation; or
2. Evidence of a "pattern or practice" of the same violation committed by that employer at more than one of the employer's worksites.

If the employer fails to rebut the presumption that a violation is "enterprise-wide," then the division may issue an enterprise-wide citation requiring enterprise-wide abatement.

"Egregious" Violations

SB 606 also directs Cal/OSHA to issue an "egregious violation" if one or more of the following is true:

1. The employer, intentionally, through conscious, voluntary action or inaction, made no reasonable effort to eliminate the known violation.
2. The violations resulted in worker fatalities, a worksite catastrophe, or a large number of injuries or illnesses. For purposes of this paragraph, "catastrophe" means the inpatient

hospitalization, regardless of duration, of three or more employees resulting from an injury, illness, or exposure caused by a workplace hazard or condition.

3. The violations resulted in persistently high rates of worker injuries or illnesses.
4. The employer has an extensive history of prior violations of this part.
5. The employer has intentionally disregarded their health and safety responsibilities.
6. The employer's conduct, taken as a whole, amounts to clear bad faith in the performance of their duties under this part.
7. The employer has committed a large number of violations so as to undermine significantly the effectiveness of any safety and health program that may be in place.

The conduct underlying a violation determined to be egregious must have occurred within the five years preceding an egregious violation citation. Once a violation is determined to be egregious, that determination remains in effect for five years. After that five-year period has elapsed, additional evidence is required to support any subsequent egregious violation.

If Cal/OSHA "believes that an employer has willfully and egregiously violated" a safety standard, then Cal/OSHA "shall issue a citation to that employer for each egregious violation." Critically "each instance" that an employee is exposed to the violation alleged to be an egregious violation "shall be considered a separate violation for purposes of the issuance of fines and penalties." This means that if an employee is exposed to the same cited hazard each day at work, the employer could be cited with multiple violations, which could significantly increase the associated fines.

Subpoenas, Injunctions, and Temporary Restraining Orders

SB 606 authorizes Cal/OSHA to issue a subpoena if the employer fails to "promptly provide" requested information during an inspection, and may enforce the subpoena if the employer "fails to provide the requested information within a reasonable time. These time limits are not defined. The bill also expands Cal/OSHA's authority to seek injunctions and temporary restraining orders. Specifically, if Cal/OSHA has "grounds to issue a citation" under section 6317, then Cal/OSHA may seek an injunction in superior court restraining the use or operation of equipment until the cited condition is corrected. Upon filing an affidavit showing that Cal/OSHA has grounds to issue a citation under section 6317, the court may issue a temporary restraining order.

Impact on Employers

These substantive amendments greatly increase the enforcement authority of Cal/OSHA. Employers with multiple worksites in the state will typically have one set of written procedures that are used at all worksites, such as written Injury Illness and Prevention Programs, Hazard Communication Programs, and Heat Illness Prevention Programs. A deficiency in these written programs now provides a basis for issuing an "enterprise-wide" citation and potentially requiring "enterprise-wide" abatement.

In addition, Cal/OSHA's new authority to issue egregious violations is broad and not clearly defined. Cal/OSHA need only establish one of the seven bases for finding an employer's conduct "egregious." Many of the bases contain undefined terms, such as "large number" of injuries or illness, "large number" of violations "that undermine significantly the effectiveness of any safety and health program," "extensive history" of prior violations, or "persistently high" injury rates. Furthermore, the bill states that Cal/OSHA "shall" issue an egregious violation if the criteria are established, meaning that Cal/OSHA is required to issue that citation. The use of the word "shall" in the bill could limit the ability of an employer to pursue a reclassification of these violations through settlement.

Employers should carefully review written programs to ensure compliance with all applicable requirements, including ensuring that required trainings are scheduled and a system is in place to document that those trainings occur. Reviewing these policies and procedures could reduce the likelihood of receiving an enterprise-wide violation or an egregious violation.

Should an employer receive a citation, the employer should promptly respond to information requests and communicate when documents will be produced to minimize the likelihood of receiving a subpoena.

I realize this law could have serious consequences for many employers who are unfortunate enough to get ensnarled in its effects. I will be watching for forthcoming webinars that many of my law firm colleagues specializing in labor law will be hosting and pass them along ASAP!

Settlement Agreements

SB 331 Leyva (Chapter 638) significantly expands on laws passed over the previous few years limiting the ability to use confidentiality clauses in severance and settlement agreements. Prior to SB 331, any settlement agreement in a case where sexual harassment, sexual assault or discrimination based on sex has been alleged couldn't include a confidentiality provision prohibiting disclosure of information regarding the claim.

SB 331 expands the prohibition to include acts of workplace harassment or discrimination based on **any** characteristic protected under the Fair Employment and Housing Act, not just those based on sex. While employees cannot be prohibited from discussing underlying facts of the case, employers can still use clauses that prevent the disclosure of the amount paid to settle the claim. SB 331 will apply to agreements entered on or after January 1, 2022.

COVID-19

This is a bill that our business coalition played a significant role in 'shaping.'

The Governor signed **AB 654 Reyes (Chapter 522)** which clarifies and cleans up last year's COVID-19 notice and reporting bill, AB 685. The bill revises the language 685 used to describe COVID-19 notice requirements to make it more consistent throughout. **This was an urgency measure that took effect immediately upon signing.**

Last year's AB 685 established the COVID-19 notification framework employers have become familiar with; that is, when an employer receives notice of a potential COVID-19 exposure, the employer must, within one business day, provide certain employees with written notice of three things: (1) the potential exposure, (2) information on COVID-19-related benefits, and (3) information on the disinfection and safety plans that the employer plans to implement.

As is typical when a new bill on a new subject matter becomes law, AB 685 contained inconsistencies, specifically in the terminology used to describe to whom notices would be given. For example, when it came to providing notice of potential exposure, employers were required to give the notice to all employees and employers of subcontracted employees "who were on the premises at the same worksite as the qualifying individual within the infection period;" but, for the information on COVID-19-related benefits, the law required employers to provide notice to "all employees who may have been exposed." For information on disinfection and safety, the law was even broader, requiring notice to "all employees and the employer of subcontracted workers." These different phrases suggested employers had to potentially send different information to different groups of employees.

The changes made with the newest measure, AB 654, cleans up this language and makes it more consistent. Specifically, regarding the obligations to provide information on COVID-19-related benefits and the disinfection and safety information, the language was revised to require employers to send notice to employees who were "on the premises at the same worksite as the qualifying individual within the infectious period."

The new law also revises the time frame in which employers must give notice of COVID-19 outbreaks to local public health agencies. The prior version required notice of outbreaks within 48 hours. AB 654 revises that to "within 48 hours or one business day, whichever is later." It also specifically exempts certain health facilities from the requirement to report outbreaks to local health agencies because those facilities already report outbreaks under other legal requirements.

The new law revises certain terminology to better correspond to the terms of federal and other state COVID-19-related provisions.

I will be working with my labor law colleagues to provide you with recommended changes that you should make to your COVID-19 notice and reporting policies ASAP. Stay tuned!

Under SB 336 Ochoa Bogh (Chapter 487), when the California Department of Public Health (CDPH) or a local health officer issues an order or mandatory COVID-19-related guidance, they must publish the order or guidance on their website along with the date that the order or guidance takes effect. The CDPH or local health officer must also create an opportunity to sign up for an email distribution list to receive updates on the order or guidance. This measure will hopefully make it easier for businesses to track and implement the most current COVID-19 orders and guidance. SB 336 also went into effect immediately upon signing.

Forthcoming Cal/OSHA COVID Regulation

In addition to the new laws, employers should continue to monitor additional COVID-19 regulatory developments. On **October 20, 2021,** California's Division of Occupational Safety and Health (known as Cal/OSHA) issued proposed language for the second readoption of Emergency Temporary Standards (ETS) for COVID-19 Prevention. The readoption would provide for the proposed regulation to be in place from January 14, 2022, to April 14, 2022.

Highlights of the Proposed ETS Revision

The new proposal does not change the definitions of the ETS but does include substantive changes, including the following.

COVID-19 Prevention

With regard to COVID-19 prevention, the proposal changes the following sections.

3205(c)(2): During screening for employees, face coverings must be used for both vaccinated and unvaccinated employees.

3205(c)(3)(B)(5): If a case occurs in the workplace, employers would be required to provide testing for all non-symptomatic close contacts, including those who are vaccinated.

3205(c)(5): Employers are required to make COVID-19 testing available to both vaccinated and unvaccinated employees.

3205(c)(9): This section includes a few changes to exclusion protocols after a close contact. These include changes to:

- (9)(B), which states that if an employer does not exclude an employee pursuant to one of the below exceptions, then the employer must provide "information about any applicable

precautions recommended by CDPH [the California Department of Public Health] for persons with close contacts."

- (9)(B)(1) & (2), which requires vaccinated workers (or those with natural immunity) who remain asymptomatic and are not excluded to wear a face covering for 14 days after close contact, maintain social distancing for 14 days, and get a COVID-19 test 3-5 days after close contact.

3205(c)(10)(D): The proposal revises this return-to-work provision to provide that, if an individual returns to work before 14 days, he or she must wear a face mask and maintain social distancing until 14 days have passed. In other words, if an employee returns after 10 days or 7 days due to a negative polymerase change reactions (PCR) test, he or she must wear a face mask and maintain 6 feet distancing for the remaining 7 or 4 days, respectively.

Outbreaks

- 1(b): In an outbreak, employers will be required to test even vaccinated individuals in an exposed group.

Employer Provided Housing

- 3(c): Previously, ventilation had to be maximized only if some individuals were unvaccinated. Under the proposal, this is a requirement regardless of vaccination status. Housing unit ventilation must be maximized no matter whether workers are vaccinated or unvaccinated.
- 3(g): All employee residents must be tested if there were 3 or more cases in their housing unit in a 14-day period.
- 3(h)(1): Housing quarantine policies presently exclude asymptomatic vaccinated close contacts from being quarantined, but this exception is being removed.

Employer Provided Transportation

- 4(c)(2): In transit, all employees, regardless of vaccination status, must be provided with and wear face masks.

Timeframe for Compliance

The California Occupational Safety and Health Standards Board will vote on these proposed changes to the ETS. However, the proposal was **NOT** on the meeting agenda back on October 21, 2021. Any vote to adopt the proposed regulations will occur at a future Standards Board meeting. Additionally, a federal emergency regulation related to vaccines is on its way, after which Cal/OSHA will be required to adopt an equivalent or more stringent standard within 30 days.

ALL BILLS SIGNED BY THE GOVERNOR THAT IMPACT YOUR BUSINESS BY SUBJECT MATTER

Following are the highlights of bills **signed by the governor** that I tracked on your behalf this session, sorted according to subject matter. To access the complete text of a bill, click on the blue bill number link and then on the Chaptered PDF. All Chaptered bills become law effective January 1, 2022 unless it states it is an urgency measure which means it became law immediately upon the governor's signature; OR lists another effective date.

CCPA

AB 1391 (Chau) Chapter 594, Statutes of 2021. - Unlawfully obtained data.
The California Consumer Privacy Act of 2018 authorizes a consumer whose nonencrypted and nonredacted personal information, as defined, is subject to an unauthorized access and exfiltration, theft, or disclosure as a result of a business' violation of the duty to implement and maintain reasonable security procedures and practices appropriate to the nature of the information to protect the personal information may institute a civil action, as specified. This bill would make it unlawful for a person to sell data, or sell access to data, that the person has obtained or accessed pursuant to the commission of a crime and would also make it unlawful for a person, who is not an authorized person, as defined, to purchase or use data from a source that the person knows or reasonably should know has obtained or accessed that data through the commission of a crime.

Employer/Employee

AB 654 (Reyes) Chapter 522, Statutes of 2021. - COVID-19: exposure: notification.
The California Occupational Safety and Health Act of 1973 authorizes the Division of Occupational Safety and Health to prohibit the performance of an operation or process, or entry into that place of employment when, in its opinion, a place of employment, operation, or process, or any part thereof, exposes workers to the risk of infection with COVID-19, so as to constitute an imminent hazard to employees. Current law requires that the prohibition be issued in a manner so as not to materially interrupt the performance of critical governmental functions essential to ensuring public health and safety functions or the delivery of electrical power or water. Current law requires that these provisions not prevent the entry or use, with the division's knowledge and permission, for the sole purpose of eliminating the dangerous conditions. This bill would add the delivery of renewable natural gas to the list of utilities that the division's prohibitions are not allowed to materially interrupt.

AB 1033 (Bauer-Kahan) Chapter 327, Statutes of 2021. - California Family Rights Act: parent-in-law: small employer family leave mediation: pilot program.
Current law, the Moore-Brown-Roberti Family Rights Act, commonly known as the California Family Rights Act, which is a part of FEHA, makes it an unlawful employment practice for an employer, as defined, to refuse to grant a request by an eligible employee to take up to 12 workweeks of unpaid protected leave during any 12-month period for family care and medical leave, as specified. Current law defines family care and medical leave to include, among other things, leave to care for a parent. This bill would additionally include leave to care for a parent-in-law within the definition of family care and medical leave, and would make other conforming changes.

SB 331 (Leyva) Chapter 638, Statutes of 2021. - Settlement and non-disparagement agreements.
Current law prohibits a settlement agreement from preventing the disclosure of factual information regarding specified acts related to a claim filed in a civil action or a complaint filed in an administrative action. These acts include sexual assault, as defined; sexual harassment, as defined; an act of workplace harassment or discrimination based on sex, failure to prevent such an act, or retaliation against a person for reporting such an act; and an act of harassment or discrimination based on sex by the owner of a housing accommodation, as defined, or retaliation against a person for reporting such an act. This bill would clarify that this prohibition includes provisions which restrict the disclosure of the information described above. For purposes of agreements entered into on or after January 1, 2022, the bill would also expand the prohibition to include acts of workplace harassment or discrimination not based on sex and an act of harassment or discrimination not based on sex by the owner of a housing accommodation.

SB 657 (Ochoa Bogh) Chapter 109, Statutes of 2021. - Employment: electronic documents.
Current law regulates the wages, hours, and working conditions of any worker employed in any occupation, trade, or industry, whether compensation is measured by time, piece, or otherwise, except as specified. This bill would provide that, in any instance in which an employer is required to physically post information, an employer may also distribute that information to employees by email with the document or documents attached. The bill would specify that this does not alter the employer's obligation to physically display the required posting.

Health

SB 336 (Ochoa Bogh) Chapter 487, Statutes of 2021. - Public health: COVID-19.
Would require, when the State Department of Public Health issues a statewide order or mandatory guidance, or when a local health officer issues an order, related to preventing the spread of COVID-19, as defined, or protecting public health against a threat of COVID-19, that they publish on their internet website the order or guidance and the date that the order or guidance takes effect. The bill would also require the department or local health officer to create an opportunity for local communities, businesses, nonprofit organizations, individuals, and others to sign up for an email distribution list relative to changes to the order or guidance.

Safety

SB 606 (Gonzalez) Chapter 336, Statutes of 2021. - Workplace safety: violations of statutes: enterprise-wide violations: egregious violations.
Current law requires the Division of Occupational Safety and Health to issue a citation for a violation of provisions relating to the spraying of asbestos, or any standard, rule, order, or regulation established pursuant to specified provisions of the California Occupational Safety and Health Act of 1973 if, upon inspection or investigation, the division believes that an employer has committed a violation. Current law imposes penalties of certain maximum amounts depending on whether the violation is serious, uncorrected, or willful or repeated. Current law authorizes the division to seek an injunction restraining certain uses or operations of employment that constitute a serious menace to the lives or safety of persons, as specified. This bill would create a rebuttable presumption that a violation committed by an employer that has multiple worksites is enterprise-wide if the employer has a written policy or procedure that violates these provisions, except as specified, or the division has evidence of a pattern or practice of the same

violation committed by that employer involving more than one of the employer's worksites. The bill would authorize the division to issue an enterprise-wide citation requiring enterprise-wide abatement if the employer fails to rebut such a presumption.

Workers Compensation

AB 845 (Rodriguez) Chapter 122, Statutes of 2021. - Disability retirement: COVID-19: presumption.

Current law prescribes various requirements for the organization and administration of public retirement systems, which typically provide pension, disability, and death benefits to their members. Current law provides that participants in certain membership categories may be entitled to special benefits if death or disability arises in the course of employment. The California Public Employees' Pension Reform Act of 2013 (PEPRA) generally requires a public retirement system, as defined, to modify its plan or plans to comply with that act and establishes, among other things, limits on defined benefit formulas and caps on pensionable compensation. This bill, until January 1, 2023, would create a presumption, applicable to the retirement systems that PEPRA regulates and to specified members in those systems, that would be applied to disability retirements on the basis, in whole or in part, of a COVID-19-related illness. In this circumstance, the bill would require that it be presumed the disability arose out of, or in the course of, the member's employment. The bill would authorize the presumption to be rebutted by evidence to the contrary, but unless controverted, the applicable governing board of a public retirement system would be required to find in accordance with the presumption.

AB 1511 (Committee on Insurance) Chapter 627, Statutes of 2021. - Insurance: omnibus.

Current law generally regulates insurance and creates the Department of Insurance, headed by the Insurance Commissioner. Current law requires all public records of the department and the commissioner that are subject to disclosure under the California Public Records Act to be available for inspection and copying, as specified, at the offices of the department in the San Francisco Bay area, in the City of Los Angeles, and in the City of Sacramento. This bill would eliminate the reference to an office in the San Francisco Bay area and instead refer to the department's offices in the City of Oakland, the City of Los Angeles, and the City of Sacramento.

AB 1541 (Committee on Insurance) Chapter 305, Statutes of 2021. - Insurance: Guarantee Association.

Current law establishes the California Insurance Guarantee Association (CIGA) to provide coverage against losses arising from the failure of an insolvent property, casualty, or workers' compensation insurer to discharge its obligations under its insurance policies. Current law gives CIGA the ability to request the issuance of bonds by the California Infrastructure and Economic Development Bank to more expeditiously and effectively provide for the payment of covered claims arising from the insolvencies of insurance companies providing workers' compensation insurance. Current law requires that any bonds that provide funds for covered claim obligations for workers' compensation claims be issued, as specified, prior to January 1, 2023. This bill would extend the date for bonds to be issued to provide funds for covered claim obligations for workers' compensation claims, as specified, to January 1, 2026.

On To 2022!

SO NOW WHAT? The 2022 legislative agenda is already taking shape, particularly it appears, with workers' compensation. While the reforms contained in SB 863 from ten years ago have been a tremendous success, saving employers billions, the unions (with major prodding from the Applicant Attorneys) believe that 2022 will be the best year to seek benefit increases, along with possible blanket presumption changes, and other 'goodies.' Of course, these major cost-drivers would have to be balanced with offsets.

This is where I need your assistance. As I previously mentioned, I have been asked to begin working with the key players (as I have done many times in the past) on discussing a framework of issues to be placed 'on the table.' I need help from all of you 'in the trenches' to provide me with your thoughts, ideas, and suggestions on key issues that can be brought to the table that would be 'ripe' for reform to help offset the cost-drivers that would result from benefit increases, presumptions, etc. I'm literally all ears to any and all suggestions you may have. Feel free to email me at: **phil@pvgov.com**

In terms of other things looking eminent for 2022, it's clear lawmakers will try to place a constitutional amendment on next year's ballot overhauling California's recall process, the contents of which will be shaped by what can get two-thirds' support in Sacramento and pass muster with voters . The oil spill defiling the waters off Orange County's coast will spur efforts to entirely shut down offshore drilling in state waters. Now that California will require students to get vaccinated for coronavirus, lawmakers may try to tighten up personal belief exemptions.

There are the 2-year bills that have carried-over from 2021. While some, such as the presumption bills AB 334 (Mullin) & SB 284 (Stern), will have the entire session of 2022 to sit on the inactive file only to be brought up on a moment's notice on the other house's floor, those that did not move out of their house of origin have through January, 2022 to make it through their house or die. Fingers crossed most end up with this deadline fate!

If that wasn't enough, don't forget we're heading into an election year. A half-dozen battleground seats could swing control of the House. Newsom is up for reelection and Progressive Attorney General **Rob Bonta** will need to defend his seat. Insurance Commissioner **Ricardo Lara** will look to fend off an intraparty challenge from **Assemblyman Mark Levine**. Los Angeles is choosing a new mayor. There will be ballot initiative fights over sports wagering and medical malpractice and recycling. Voters could also get the chance to ban public employee unions, expand school choice, and open battles over teacher employment rules by enshrining a right to a quality public education.

Before the voting will come the new maps. Prospective candidates are in a state of suspense as they wait to see the shape of new districts. Once the California Citizens Redistricting Commission releases the new contours in late December, look out: The churn of retirements and the campaign launches that follow will also reshape the political landscape. Hold on to your seat and hat! It's going to be a long, contentious and above all, VERY interesting year!

ADDITIONAL SERVICES PROVIDED

I want to remind you of having direct access through me into "the government" to resolve **any and all** problems or to address **any** need that may arise. Regardless of the problem or issue, **call me!** Even if I don't have the immediate answer or solution, my almost (ugh!) 49 years in Sacramento means that I most likely know someone who can assist us with your problem or issue! I may be reached at (916) 784-7055, or by email phil@pvgov.com

Thank you for allowing me to serve as your legislative advocate. It is truly an honor and a privilege! Finally, 2022 will be my 18th year of representing your interests before state government. I can't wait!

EXHIBIT 3 –

AIMS Transition/Implementation Plan

Sample
Implementation Plan

Sample Implementation Plan

ACCLAMATION INSURANCE MANAGEMENT SERVICES

Loss Portfolio Management ®

***Dates will be identified and based on the effective date of contract.**

Program Management			
TASK		**RESPONSIBILITY**	**DUE DATE**
☐	Obtain signed Service Agreement – Notify Operations of changes to RFP	AIMS	TBD*
☐	Meet with the NEW CLIENT to: • Discuss employees and the current/preferred staffing plan • Confirm banking procedures, exchange financial information • Determine claims systems specifics, etc. • Determine vendor panel	VP Operations, IT, HR, and Account Manager	Schedule after signed agreement
☐	Meet with the NEW CLIENT to: • Discuss work flow • Establish goals for program • Review Cost Avoidance Reports with the NEW CLIENT. Determine which reports, to whom, and the frequency to be provided to the NEW CLIENT • Determine schedule for annual evaluation, client training and claim reviews	VP Operations, IT, and Account Manager	3-days after signed agreement
☐	Trust account funded	VP Operations	90-days after signed agreement
☐	Files physically transferred from Current TPA. Open and closed files stored by Current TPA will be moved and stored by the NEW CLIENT's choice of storage facility. Fees associated with moving and storage of files would be provided at cost.	VP Operations	90-days after signed agreement
☐	Meeting with the NEW CLIENT to discuss conversion	VP Operations, IT, and Account Manager	120-days after signed agreement
☐	Review findings and status of takeover with the NEW CLIENT • Adjust program goals if indicated • Priority claims identified and discussed • Initial plan of action identified for each file • Nuisance value claims identified	Account Manager, Supervisors	5 months after signed agreement

Sample Implementation Plan

ACCLAMATION INSURANCE MANAGEMENT SERVICES

Loss Portfolio Management ®

Personnel			
ACTION		**RESPONSIBILITY**	**DUE DATE**
☐	Send internal notice of new client to staff	Operations	3-days after signed agreement
☐	Notify Current TPA employees of AIMS job postings and company benefits, potential employee to provide letter of interest due TBD, request latest resume.	HR Representative	8-days after signed agreement
☐	Post job listings on Monster.com and AIMS website	HR Representative	8-days after signed agreement
☐	Place advertisements in regional newspapers, industry publications	HR Representative	8-days after signed agreement
☐	HR/Claims team begin interview process	VP Operations and HR	12-days after signed agreement
☐	Request release of personnel information from viable candidates	HR Representative	12-days after signed agreement
☐	Place job orders with Temporary Staffing Agencies	HR Representative	45-days after signed agreement
☐	Hire staff	HR Representative	77-days after signed agreement
☐	Complete orientation check list/schedule orientation meeting for new hires	HR Representative	77-days after signed agreement

Sample Implementation Plan

ACCLAMATION INSURANCE MANAGEMENT SERVICES

Loss Portfolio Management ®

Technical			
ACTION		**RESPONSIBILITY**	**DUE DATE**
☐	Provide sample letters to client/former TPA - Guidelines of transfer	VP Operations	3-days after signed agreement
☐	Request passwords and obtain first trust file for conversion from Current TPA	IT	14-days after signed agreement
☐	Obtain names and addresses of claims system users	IT	31-days after signed agreement
☐	Complete First Draft of Client Profile, review with the NEW CLIENT	Account Manager	60-days after signed agreement
☐	Provide claim kits and medical panel to each NEW CLIENT campus	Account Manager	75-days after signed agreement
☐	Set up data system with managed care provider	IT	75-days after signed agreement
☐	Set up Banking File	IT	75-days after signed agreement
☐	Send letter to injured workers, service providers, etc.	Account Manager and IT	75-days after signed agreement
☐	Data transfer	IT	87-days after signed agreement
☐	Final Client Profile distributed	Account Manager	3-months after signed agreement
☐	Verify Claims Logs received	Account Manager	3-months after signed agreement
☐	Identify cases on delay and verify appropriate due dates and POA	Account Manager	3-months after signed agreement
☐	All NEW CLIENT campuses on-line access to claims system complete	IT	3-months after signed agreement

Sample Transition Plan Documents

Transition Sample Timeline:

03/DD/2020: Date TPA notification/Board Contract approval obtained

03/DD/2020: TPA instruction letter sent out to all parties after Client approval obtained. Detailed letter outlining the transition plan, to include data delivery request and advance payments.

03/DD/2020: Outlook appointment requests sent to prior TPA for weekly meeting. Outlook appointment requests sent to Client for weekly meeting. Outlook appointment request sent to internal participants for weekly meeting.

03/DD/2020: Individual agendas sent out for first weekly meetings -

- Internal
- Client
- Prior TPA

03/DD/2020: Estimated date test data delivered from prior TPA with balancing reports and data dictionaries. Receipts of all required elements sets the 60 day data conversion clock.

03/DD/2020: Data conversion issues completed and await delivery of final data.

03/DD/2020: Delivery of final data and images received with balancing reports.
Estimated data live date = MM/DD/2020 *to* MM/DD/2020.

Sample Client / Agenda Topics:

WEEK #:

1. 03/DD/2020: Overview of Process, Data Conversion Timeline, Banking, Staffing
2. 03/DD/2020: Follow-up Banking, Staffing, Claim Access, and discussion for on line training to report claims, and discuss who needs access and appropriate level. MPN and NCM for triage and transition. Discuss status of TPA call and issues and any outstanding follow up items.
3. 03/DD/2020: Discuss Organization Tree Set-Up, Excess Policy Information, and follow-up on Banking and Staffing, transition to Pharmacy Benefit Program. Discuss status of TPA call and issues and any outstanding follow-up items.
4. 03/DD/2020: Discuss Setting-up in person meetings for initial meeting with claims team and departments for a Meet and Greet, or Open house. Begin detailed discussion for written Service Guidelines regarding authority levels, Vendor Panel, Medical Providers. Discuss status of TPA call and issues and any outstanding follow-up items.
5. 03/DD/2020: Confirm Banking Progress and Funding. Begin work on updating Medicare Reporting profile. Verify receipt of any requested documents. Discuss status of TPA call and issues and any outstanding follow up items.
6. 03/DD/2020: Discuss rough draft of written Service Guidelines for any modifications. Discuss status of TPA call and issues and any outstanding follow up items.
7. 03/DD/2020: Staffing updates, receipt of RRE information, excess policy information. Discuss status of TPA call and issues and any outstanding follow-up items.
8. 03/DD/2020: Staffing updates. Discuss status of TPA call and issues and any outstanding follow-up items.
9. 03/DD/2020: Finalize written Service Guidelines. Discuss status of TPA call and issues and any outstanding follow-up items.
10. 03/DD/2020: Staffing updates, verify special letters or forms and vendors are added to the system. Discuss status of TPA call and issues and any outstanding follow-up items.
11. 03/DD/2020: Finalize banking and verify funding. Discuss status of TPA call and issues and any outstanding follow up items.
12. 03/DD/2020: Client webinars for online reporting, Meet and Greets with claim staff and departments. Discuss hot cases with Risk Management prior to transfer. Discuss status of TPA call and issues and any outstanding follow-up items.
13. 03/DD/2020: Confirm receipt of final data and images, advanced payments
14. 03/DD/2020: Confirm data transition complete

Sample Meeting Agendas

ACCLAMATION INSURANCE MANAGEMENT SERVICES

Agenda

CLIENT's NAME:

TPA Transition Meeting Schedule

Location: Call in number assigned

Date/Time/: Every Tuesday, 10:00 – 10:45 am

AIMS Attendees:

NAME	TITLE	PHONE NUMBER / EMAIL

CLIENT Attendees: ***(via phone as needed)***

NAME	TITLE	PHONE NUMBER / EMAIL

Week 1

- Exiting TPA Letter & Notice to Award to AIMS
- Expectations for the Exiting TPA Program
- Advance Payments (Disability) – Weeks Ahead
- Client involvement in Examiner selection
- Existing Bill Review & Utilization Review Cut Over

Supporting Documents:

Time	Agenda Topic	Artifacts	Owner	Notes

ACCLAMATION INSURANCE MANAGEMENT SERVICES

Agenda

CLIENT NAME

TPA Transition Meeting #2

Location: 1 877 309 2073, Access Code:978-165-685

Date/Time: MONTH DD, 20YY _____ to _____

Attendees:

NAME	TITLE	COMPANY	ATTENDED
Tricia Baker	AVP Operations	AIMS	
TBD	Claims Manager	AIMS	
Lynn Cavalcanti	Sr. VP Operations	AIMS	

Agenda:

ITEM #	TOPIC	OWNER	DUE DATE
1.	Data Conversion: Timeframe ____ delivery = ____	Tina Patterson	MM/DD/YYYY
2.	Banking: AIMS sets up new account?	Jeff Russo	MM/DD/YYYY
3.	Claim Access and Reports	Tina Patterson	MM/DD/YYYY
4.	Claim Service Guidelines	TBD	MM/DD/YYYY
5.	Staffing	TBD	MM/DD/YYYY

ACCLAMATION INSURANCE MANAGEMENT SERVICES

Agenda

CLIENT NAME

TPA Transition Meeting #2

Location: 1 877 309 2073, Access Code:978-165-685

Date/Time: MONTH DD, 20YY 11:00 a.m. to 11:30 a.m.

Attendees:

NAME	TITLE	COMPANY	ATTENDED
Tricia Baker	AVP Operations	AIMS	Yes
TBD	Claims Manager	AIMS	Yes
Lynn Cavalcanti	Sr. VP Operations	AIMS	No

AGENDA:

ITEM #	TOPIC/NOTES	OWNER	DUE DATE
1.	Data Conversion: Timeframe MONTH DD, 20YY delivery = MONTH DD, 20YY	Tricia Baker/ Tina Patterson	
2.	Banking: CLIENT setting up new positive pay account. CLIENT believes it will be open soon. CLIENT needs AIMS to reconcile and manage with their finance department. Targeting meeting the first week of December with AIMS and Finance departments to discuss access and responsibilities, communication.	Tricia Baker/ Chris Vergers	
3.	Claim Access and Reports: CLIENT will send over the reports they currently receive and want to continue to receive on monthly, quarterly, annual basis.	Tricia Baker/Tina Patterson	
4.	Claim Service Guidelines: CLIENT will send over the rough draft to me and Janine by MONTH DD, 20YY 2:00 p.m. so that Janine can review the information while she is on vacation.		
4.	Claim Service Guidelines: Janine will contact after she returns. They will decide if they need to meet in person.	TBD	
5.	Staffing- Janine updated with her current contacts and status. The goal is to hire in the new employees by MONTH DD, 20YY or the first week of MONTH DD, 20YY depending on new candidate availability.	Tricia Baker/ TBD	
6.	MPN: ____ needs to discuss MPN issues with Lea. They currently have their own MPN and they like to control having providers. If we are able to narrow down the MPN to fit their needs, they will consider using our MPN.	Tricia Baker/ Lea Mendez	
7.	Nurse Case Management: ____ will obtain a list of NCM assignments from ____ with a status report for mid-December. This will allow AMC	TBD	

ITEM #	TOPIC/NOTES	OWNER	DUE DATE
	time to review and discuss potential assignments that need to be transferred or closed out.		
7.	Triage: Not at this time, but maybe later. The prior administrator used the triage program to prop up the inexperience claim staff. _____ may be open to using at a later time but would need to discuss and understand how the program would work.	Tricia Baker/ Lea Mendez	N/A
8.	PBM: Tricia will need to work with Healthesystems and _____ to update on when the files can transition, when the cards will go out to the open inventory and obtain the first fill cards.	Tricia Baker/ Corporate Compliance	
9.	Reporting new claims. _____ would like to have new claim reporting training to take place on MONTH DD, 20YY with her WC Coordinators. _____ would like them to see the system. We can also provide a webinar at a later date for anyone who missed the training or needs additional training. Client Contact will work on obtaining a list of the WC coordinators for their IDs. She will include their name, title, department, email and phone number._____ confirms they should only have access to their department. _____ would like a link to our reporting system for their website that takes them to our portal.	Tricia Baker/ Tina Patterson	
10.	WC Claim Packets: _____ needs 300 DWC 1 forms. Tricia will check to see if we can put the packets together._____ states her packets contain the 5020, DWC 1, Supervisor Instructions for completing the packet. WC Clinic list, MPN network information, and 1st fill prescription form.	Tricia Baker/ Tina Patterson	

CLIENT Contacts:

NAME/EMAIL: HR Analyst and assisting with WC transition and Claims.

NAME/EMAIL: HR Analyst and works on RTW and Employment Issues

NAME/EMAIL: Clerical and billing

Weekly Transition Meeting with Client:

Starting Wednesday,

ACCLAMATION INSURANCE MANAGEMENT SERVICES

EXHIBIT 4 –

Team Resumes for AIMS & AMC

AIMS Proposed Team

ACCLAMATION INSURANCE MANAGEMENT SERVICES

Kim Silas, Claims Manager

SUMMARY OF EXPERTISE

Oversees the handling of all aspects of the claims assigned to the unit, maintain a current diary system, reviews job performance, review claims for reserve adequacy, maintain professional relationship and communication with client.

KEY RESPONSIBILITIES

- Identify and verify that staff understands the company commitments, standards of performance and client expectations.
- Attend client board meetings, claim reviews, and conduct training for clients.
- Attend oral evaluations for new client business.
- Prepare power point presentations and present for all potential and existing clients; including client board meetings.
- Assist client concerns while involving appropriate company management with client follow up.
- Manage, prepare, and respond to all audits.
- Manage and prepare all training needs.
- Prepare and submit yearly Self Insurance Program (SIP) annual reports for all clients.
- Plan, organize, coordinate the work of human resource and technical staff; selects, hires, coaches, counsels, discipline and termination. As well as making other personnel decisions.

RELEVANT EXPERIENCE

2011 – Present – **Acclamation Insurance Management Services** – Claims Manager

2005 - 2011 – **York Insurance Service Group** – Unit Manager/Senior Claims Examiner

2004-2004 - **Claims Management, Inc.** – Sr. Claims Examiner

2002-2004 – **Intercare Insurance –** Claims Examiner

2001-2002 – **American Commercial Claims Administrator –** Claims Examiner

ACCLAMATION INSURANCE MANAGEMENT SERVICES

Kim Silas, Claims Manager

EDUCATION / CERTIFICATIONS

- 1989 – 1990 College of San Mateo
- Self Insurance Certificate for Worker's Compensation
- Insurance Education Association WCCA Workers' Compensation Claims Administration Certificate
- Insurance Education Association WCCA Workers' Compensation Claims Professional Certificate

AIMS Corporate Management Team

ACCLAMATION INSURANCE MANAGEMENT SERVICES

Dominic Russo, President & CEO

SUMMARY OF EXPERTISE

Dominic has served as President of Acclamation Insurance Management Services, Inc. (AIMS) since 1994. In 2011, he assumed the leadership role of President & CEO for both AIMS and Allied Managed Care, Inc. (AMC), (the Company). Under his stewardship, the Company consistently meets its corporate objective to –

"Deliver measurable financial results to our Clients through intelligent use of sophisticated technology and a flexible yet disciplined approach to service delivery with fiscal accountability. We nurture long-term relationships by providing our Clients with technically competent, experienced, and dedicated staff acting with integrity in all that we do."

KEY RESPONSIBILITIES

- Provides overall strategic leadership to the Company.
- Works with Board of Directors and Executive Management Team to establish long-range goals, strategies, plans, and policies.
- Oversees compliance of State Regulations and Carrier/ Client needs.
- Ensures Client satisfaction and partnership objectives.
- Maintains and spearheads profitability of the Company.

RELEVANT EXPERIENCE

2011 – Present AIMS / AMC – *President & CEO*

1980 – 2011 AIMS

- *President & COO (1994 – 2011)*
- *Various Management Roles (1987–1994)*
- *Claims Examiner (1980 –1987)*

EDUCATION / CERTIFICATIONS

- College of Marin, Associate Degree in Business
- Harvard Business School, Graduate of Owner President Management Program

ACCLAMATION INSURANCE MANAGEMENT SERVICES

Lynn Cavalcanti, Sr. VP Operations

SUMMARY OF EXPERTISE

Lynn has extensive claims experience with public entities. She serves Acclamation Insurance Management Services, Inc. (AIMS) Clients by establishing critical service, program operations, and productivity criteria; benchmarking leading-edge practices; developing marketing channels; leading commitment to quality service; evaluating service results, and representing the company to Clients (making periodic visits, exploring specific needs, and resolving problems).

KEY RESPONSIBILITIES

- Establishes effective lines of communication and feedback between branch offices.
- Oversees quality control as it pertains to Client-related concerns (monitor claims reviews, report requirements, and makes recommendations).
- Develops, writes, and revises standard operating procedures; performs annual reviews and updates standard operating procedures, and works to ensure employees meet compliance standards.
- Monitors implementation of procedures and standards to assure compliance with the law in coordination with the Client, and/or AIMS reporting responsibilities.
- Ensures compliance with all government regulated Workers' Compensation rules, guidelines, and regulations; such as those promulgated by the State of California and Health Insurance Portability and Accountability Act.
- Participates in development of system updates to achieve superior quality and reliability levels that meet regulatory and customer-related requirements.
- Provides leadership and mentoring to employees by participating in the planning, development, coordination, and presentation of specific training and educational programs.

RELEVANT EXPERIENCE

2010 – Present	**AIMS** *Senior Vice President Operations*
2003 – 2010	York Insurance Service Group / Gregory B. Bragg & Associate *Regional Branch Manager*
2002 – 2003	North Bay Schools Insurance Authority *Program Services Manager*
1993 – 2002	North Bay Schools Insurance Authority *Workers' Compensation Claims Manager*

ACCLAMATION INSURANCE MANAGEMENT SERVICES

Lynn Cavalcanti, Sr. VP Operations

EDUCATION / CERTIFICATIONS

- Long Island University, New York, BA
- University of Phoenix, California, MA
- Concord Law School, California, JD
- Associate in Risk Management (ARM) 54-passed
- Self-Insurance Certificate

COMMITTEES / ASSOCIATIONS

- 2002 – 2003 Chair Legislative, California Association Joint Powers Authority (CAJPA)
- 1996 – 2002 Subcommittee Chair, Workers' Compensation, CAJPA Speaker/ Presenter at California Coalition on Workers' Compensation (CCWC) & CAJPA Annual Conferences

ACCLAMATION INSURANCE MANAGEMENT SERVICES

Tricia Baker, Assistant VP Operations

SUMMARY OF EXPERTISE

Tricia has extensive experience in the administration of Workers' Compensation (WC) with public entities. In her career she has served in the roles of Sr. Claims Examiner, Claims Manager, Supervisor/Branch Manager, and Assistant Vice President. Tricia assists the Sr. Vice President Operations with new Client implementations and transitions, identifies and coordinates training, maintains appropriate controls, and ensures AIMS delivers as promised.

KEY RESPONSIBILITIES

- Coordinates training and implementation of regulatory changes.
- Liaison between Sr. VP and corporate departments and operating managers.
- Works closely with support areas such as Data Delivery Services and Marketing/Sales for mutually agreed upon projects.
- Creates and maintains Risk Management Information System (RMIS) generated letters.
- Assists with organization and refinement of RMIS (payment codes, diary codes, etc.).
- Attends conferences and seminars (makes contacts / educates teams).

RELEVANT EXPERIENCE

2013 - Present	AIMS *Assistant VP Operations*
2005 - 2013	York Risk Services Group *Assistant Vice President*
2001 - 2005	Liberty Mutual Insurance *Supervisor & Branch Manager*
1999 - 2001	Pegasus Risk Management *Claims Manager*
1988 - 1999	Liberty Mutual Insurance *Sr. Examiner*

EDUCATION / CERTIFICATIONS

- Bachelor of Science, Business Administration – California State University of Sacramento
- Self-Insured Plan Certificate

ACCLAMATION INSURANCE MANAGEMENT SERVICES

Cheryl Agee, VP Corporate Compliance

SUMMARY OF EXPERTISE

Cheryl has extensive experience in the administration of workers' compensation (WC) in roles such as Examiner, Supervisor, and Claims Manager. As VP Corporate Compliance, she leads the company in interpreting and implementing new work flow processes following legislative enactment. Cheryl monitors the implementation of procedures and standards to assure compliance with the law and in coordination with the Client, and/or reporting responsibilities.

KEY RESPONSIBILITIES

- Conducts analysis of work performance against best practices, which includes compliance oversight, internal audits, and quality control.
- Develops and delivers WC training programs such as ongoing technical training and standardized work flow processes, best practice implementation and revision, quality control, work measurement, management oversight practices, and development of performance standards at various levels.
- Implements and revises best practice procedures including work measurement, management oversight practices, and development of performance standards at various levels.
- Conducts internal audits and quality control.

RELEVANT EXPERIENCE

2005 – Present	Acclamation Insurance Management Services, Inc. (AIMS) ▪ *VP Corporate Compensation (2014 – Present)* ▪ *Director of Training and Compliance (2013 – 2014)* ▪ *Claims Manager (2005 – 2013)*
2004 – 2005	Southern California Risk Management Associates ▪ *Branch Claims Manager*
1993 – 2005	Cambridge Integrated Services Group, Inc. ▪ *Claims Manager*
1977 – 1992	Within this timeframe held various WC positions with the following companies: ESIS, Inc., Kemper Insurance Company, Tokio Marine Management, Inc., Republic Indemnity Insurance Company, Fairmont Insurance Company, California Indemnity Insurance Company, Mission Insurance Company, and Fremont Insurance Company

ACCLAMATION INSURANCE MANAGEMENT SERVICES

Cheryl Agee, VP Corporate Compliance

EDUCATION / CERTIFICATIONS

- West Los Angeles Community College, Majored in Business/Early Childhood Education
- Insurance Education Association Certificate of Completion Workers' Compensation
- Self-Insured Plan Certificate

Ren Johnson, VP Information Technology

SUMMARY OF EXPERTISE

Rendell ("Ren") has extensive experience in the information technology (IT) industry. A significant amount of his IT career have been in leadership positions including Director and VP in the workers' compensation (WC) industry. Ren makes strategic technology decisions and provides state of the art solutions for government, healthcare, workers' compensation, and enterprise environments. Ren oversees Client program implementation from an IT perspective.

KEY RESPONSIBILITIES

- Defines, delivers, and supports strategic plans for implementing information technologies.
- Administers the delivery of exceptional customer service.
- Identifies Company opportunities and solutions for automating business processes.
- Monitors costs and value of IT Services provided to Clients.
- Maintains competitive edge in the Company's technology offerings.

RELEVANT EXPERIENCE

2010 – Present	Acclamation Insurance Management Services, Inc. (AIMS) ▪ *VP Information Technology (2014 – Present) / IT Director (2010 – 2014)*
2004 – 2010	Professional Dynamics, Inc. ▪ *Director of Information Technology*
2003 – 2004	Wright on-line Systems ▪ *IT Project Manager*
2000 – 2003	Xtime Inc. ▪ *MIS Manager/Director*
1995 – 2000	MCI / WorldCom ▪ *Senior System Engineer (Technical Lead)*

EDUCATION / CERTIFICATIONS

- University of Phoenix, Business Administration
- Microsoft (MS) Training: Designing Microsoft Windows, Directory Services Infrastructure, Designing MS Windows Network Security, Managing Windows Network Environment, and Windows Microsoft Certified Systems Engineer (MCSE) Core
- MS Certifications: MCSE / Microsoft Certified Professional / Microsoft Certified Systems Analyst

AMC Team Resumes

Mark Denison, Sr. VP Operations

SUMMARY OF EXPERTISE

Mark provides unparalleled leadership and direction to all Allied Managed Care, Inc. (AMC) staff. He oversees all operational and administrative components of AMC's services. His experience in workers' compensation cost containment includes strong multi-jurisdictional managed care knowledge and practical application. His involvement will ensure performance standards are met and communication is excellent.

KEY RESPONSIBILITIES

- Oversees quality control as it pertains to Client-related concerns.
- Develops, writes, and updates standard operating procedures; performs annual reviews, and ensures employees meet compliance standards.
- Monitors implementation of procedures and standards to assure compliance with the law and in coordination with the Client, and/or AMC reporting responsibilities.
- Develops and maintains systems to achieve superior quality and reliability levels to meet regulatory, internal, and customer requirements.
- Provides leadership and mentoring to employees to ensure appropriate quality assurance needs by participating in the planning, development, coordination, and presentation of specific training and educational programs.

RELEVANT EXPERIENCE

2008 – Present	Allied Managed Care Inc., (AMC) *Sr. VP Operations*
2003 – 2008	Professional Dynamics Inc. *Vice President of Managed Care Services*
2001 – 2003	HealthNet, Inc. *Director of Managed Care Services*
1997 – 2001	State Compensation Insurance Fund *Medical Consultant*
1986 – 2001	Denison Chiropractic Inc. *President/Chief Executive Officer*

EDUCATION / LICENSES / TRAINING / CERTIFICATES

- Palmer College of Chiropractic - West Brigham Young University, California: 1985
- Qualified Medical Evaluator, State of California Division of Workers' Compensation Appointment: 1991–2005
- Certified Disability Evaluator: 1993
- Insurance Educational Association, Workers' Compensation Claims Administration: 2001

Alan E. Randle, M.D. Medical Director / CA Lic. G27961

SUMMARY OF EXPERTISE

Dr. Alan E. Randle (Dr. Randle) is a California-licensed physician. His experience encompasses the clinical practice of medicine, medical evaluation, management, and academia. Dr. Randle is board certified in Occupational Medicine and has ultimate oversight of all UR Department decisions, education of nurses and examiners regarding UR rules and regulations. He is a noted industry expert on Utilization Review (UR) in California. He is a presenter and instructor on the California UR process to Physicians, Claims personnel, and employers in the private and public sectors.

Dr. Randle received his medical degree from the University of San Francisco in 1973 and became certified by the American Board of Preventive Medicine in Occupational Medicine in 1989. Dr. Randle practiced Occupational Medicine while Vice President of RediCare Industrial Medical Clinic. Since then Dr. Randle has served as Medical Director for several of the largest insurance and managed care companies in the country. He joined the Allied Managed Care, Inc. (AMC) team in 2008.

KEY RESPONSIBILITIES

- Provide oversight, leadership, and medical expertise for AIMS/AMC.
- Oversee day-to-day operations of the Quality Management Program. Chairperson of the Quality Management Committee, accountable to the Company's President & CEO and Senior Vice Presidents for both AIMS/AMC.
- Work with Clients to develop a mutually agreeable process for oversight of the Claims Examiner approvals and is actively involved in the appropriate training of the claims staff in the authorization process to recognize the most appropriate claims for medical case management services.
- Oversight of all UR Department decisions.
- Educate Nurses and Claims Examiners regarding UR rules and regulations.
- Stay abreast of current changes in legislation and trains staff on new regulations.
- Conduct training sessions to ensure Claims Examiners are aware of various modalities.
- Conduct training for Clients on topics such as the best practices to use for UR.

RELEVANT EXPERIENCE

2008 – Present	AIMS/AMC ▪ *Medical Director*
1991 – Present	Occupational Medicine & Utilization Review/Medical Case Management ▪ *Private Consultant*
1978 – 1991	Readicare/California Industrial Medical Clinic Clinical Practice of Occupational Medicine ▪ *Vice-President, Redicare Medical Group*

Alan E. Randle, M.D. Medical Director / CA Lic. G27961

EDUCATION / SCHOLASTIC HONORS

- University of California, Berkeley, Bachelor of Science – 1970
- University of California, San Francisco, Medical Doctorate – 1973
- Regent's Scholar – University of California, Berkeley
- Phi Beta Kappa – University of California, Berkeley

POST-GRADUATE TRAINING (RESIDENCY)

- University of California, Los Angeles, California
- General Surgery / July 1973 – June 1976
- University of Washington, Seattle, Washington
- General Surgery / July 1976 – December 1977
- University of Cincinnati, Cincinnati, Ohio / 1985 – 1986
- Mini-Residency, Occupational Medicine

BOARD CERTIFICATION

- Certified by the American Board of Preventive Medicine, in Occupational Medicine – January 31, 1989

MEMBERSHIP IN MEDICAL ORGANIZATIONS

- Fellow, American College of Occupational and Environmental Medicine
- Western Occupational and Environmental Medical Association
  (Past Treasurer, Past Member – Board of Directors, Past Secretary)
- California Medical Association
- San Joaquin County Medical Association

CURRENT CONSULTING/PROFESSIONAL ACTIVITIES

- Medical Director, AIMS / AMC
- Medical Director, Travelers Insurance California Utilization Review Program
- Medical Advisor, Sacramento Municipal Utility District
- Medical Advisor, Republic Indemnity, San Francisco

ALLIED MANAGED CARE INCORPORATED

Lea Morales-Mendez
Director of Client Services

SUMMARY OF EXPERTISE

Lea has significant workers' compensation experience and is a bilingual (Spanish) speaker. She has worked in the areas of operations and project management and has served as Director of Operations in six different states throughout the U.S.

KEY RESPONSIBILITIES

- Assists the management team in addressing all issues related to the Client's contract as well as serving as a resource for workers' compensation decisions that may affect our Client.
- Interfaces with AMC's management team to resolve all issues that may arise in Utilization Review (UR), Bill Review (BR), Case Management (CM), Medical Provider Networks (MPN), and 24-hour nursing services.
- Provides timely communication to the management staff of any critical developments that may affect the product delivery; meets regularly with the management team to assess AMC's performance, discusses business decisions, and addresses concerns to make sure the Client is always receiving optimal service.

RELEVANT EXPERIENCE

2006 – Present	Allied Managed Care Inc. (AMC) ▪ *Director of Client Services* ▪ *Director of Operations (2006-2008)*
1991 – 2006	Concentra Integrated Services, Inc. ▪ *Director of Operations/Regional Manager*
1987 – 1991	GENEX / General Rehabilitation Services ▪ *California, Supervisor Vocational Rehabilitation Counselor*

COST CONTAINMENT EXPERTISE

- Case Management (1991 – Present)
- Utilization Review and Case Management (2006 – Present)
- Bill Review (2009 – Present)
- Medical Provider Network (2012 – Present)

EDUCATION / LICENSES / TRAINING / CERTIFICATES

- California State University, Hayward, Bachelor of Arts, Psychology
- Chabot College, Hayward, Associate of Arts
- Ergonomic Specialist – Certified
- Disability Management – Trained
- Crisis Response Trained

ALLIED MANAGED CARE INCORPORATED℠

Lea Morales-Mendez
Director of Client Services

- HIPAA (Health Insurance Portability and Accountability Act) – Trained
- URAC (Utilization Review Accreditation Committee) – Trained

ALLIED MANAGED CARE INCORPORATED

Melissa Miller, Director Bill Review

SUMMARY OF EXPERTISE

Melissa has extensive experience in the Managed Care industry including working for large national bill review companies. She has amassed a strong working knowledge of the entire bill review process.

KEY RESPONSIBILITIES

- Builds and maintains collaborative relationships and alliances with Clients.
- Ensures areas of responsibility are operating at an optimal level of experience, skill, knowledge and capability.
- Develops strategic operational and tactical business plans to achieve desired business goals for responsible operation areas.
- Provides supervisory oversight and quality control of the entire medical bill review process to ensure timely processing of payments for Clients.
- Oversees all administrative and operational components of the bill review unit, including staffing, training, quality, timeliness, and accuracy of work performed in the unit to ensure efficient and optimum workflows.
- Utilizes working knowledge of the entire bill review process to ensure objectives align with specifications noted by the Clients' Special Account Instructions.
- Manages budget and control expenses while meeting operational, financial and service requirements.

RELEVANT EXPERIENCE

2009 – Present	AMC	
		Director, Bill Review (2018)
		Division Manager Bill Review (2009 – 2017)
1997 – 2009	Health Net Plus/Coventry	
		National Account Manager
1993 – 1997	Reviewco	
		Hearing Representative/ Inquiry Specialist
1990 – 1993	Reviewco	
		Data Enterer, Auditor, Technical Analyst
1987 – 1988	Keycorp Bank	
		Coder - New York, New York

EDUCATION / LICENSES / TRAINING / CERTIFICATES

- Rose State College, Oklahoma – 1990
- University of Oklahoma – Business Finance/Accounting – 1989
- California designated Bill Reviewer

ALLIED MANAGED CARE INCORPORATED

Caroline Iverson, Division Manager
Peer Review Services

SUMMARY OF EXPERTISE

Caroline has extensive experience in the Managed Care sector covering workers' compensation Utilization Review (UR). She has been a licensed Chiropractor since 1993. As AMC's Peer Review Manager, Caroline's role is to provide an added level of auditing of the referrals and documents sent from UR nurses to Peer Review physicians and also auditing every completed Peer Review for quality and timeliness. Caroline works closely with the UR Manager and AMC's Medical Director to ensure the quality and timeliness of all Peer Reviews. She coordinates our extensive Utilization Review Quality Management Program.

KEY RESPONSIBILITIES

- Oversees coordination of referrals from UR Nurses to Peer Review.
- Confirms quality audit of Peer Reviews prior to their release.
- Manages Peer Review Physician Scheduling.
- Manages and reviews invoicing and communication between Physicians and Vendor Peer panels.
- Manages Peer Review assignments and timelines as required by the California Department of Workers' Compensation (DWC).
- Coordinates the Company's extensive Utilization Review Quality Management Program (AMC is Utilization Review Accreditation Compliant (URAC) compliant).

RELEVANT EXPERIENCE

2008 – Present	Allied Managed Care Inc. (AMC) *Peer Review Manager*
2003 – 2008	Professional Dynamics, Inc. *Peer Review Manager (2005 – 2008)* *Manager, Chiropractic Case Management and UR (2003 – 2005)*
1998 – 2004	National Health Services, Inc. (Now SHPS, Holding Inc.) *Chiropractic Physician Reviewer*
2003 – 2004	Cambridge Integrated Services *Chiropractic Physician Reviewer*
1998 – 2003	Alternative Managed Health Care *Managed Care Consultant*
1994 – 1998	Landmark Healthcare, Inc. and Landmark Healthplan *Director of Chiropractic Services*
1989 – 1994	Mid-Peninsula Back Pain Clinic (Chiropractic Private Practice) *ChiroView, Chiropractic Physician Reviewer (1992 – 1994)* *Quality Health Assurance, Chiropractic Physician Reviewer (1990 – 1992)*

ALLIED MANAGED CARE INCORPORATED℠

Caroline Iverson, Division Manager
Peer Review Services

EDUCATION / LICENSES / TRAINING / CERTIFICATES

- Pre-med studies: College of San Mateo, San Mateo, California; Foothill College, Los Altos, California
- Chiropractic: Palmer College of Chiropractic-West, Sunnyvale, California
- Member, American Chiropractic Association Managed Care and Insurance Committee, 1999 – 2005
- Advisor, Ethics Committee; California Chiropractic Association, 1993 – 1994
- Qualified Medical Examiner, 1991 – 1996
- Industrial Injury Evaluation Certification, 1990
- Managed Care Certification; California Chiropractic Association, 1993

Shannon Buelna, LVN
Director Utilization Review

SUMMARY OF EXPERTISE

Shannon has been a licensed vocational nurse for the past 15 years. She joined Allied Managed Care, Inc. (AMC) in 2008 and was promoted to Utilization Review (UR) Manager in 2014 and Director in 2022. She has clinical experience working in a physician's office, providing skilled nursing, and as director of a 199-bed assisted living facility. Her workers' compensation UR experience includes nine years working with public entities to ensure performance of UR services in accordance with the state protocols, guidelines, and regulations.

KEY RESPONSIBILITIES

- Collaborate with the Claims Examiners to ensure proper handling of each referral; understanding of claim status and medical/legal implications, and attention to Client specific instructions.
- Assist the Director of Nursing Services in the oversight of the UR program.
- Supervise and audit the dedicated UR staff;
- Ensure State and regulatory compliance such as Utilization Review Accreditation Commission (URAC) compliance.
- Assist in the implementation of Client specific instructions, and any new processes which might arise out of Division of Workers' Compensation (DWC) revisions and updates.

RELEVANT EXPERIENCE

2008 – Present	Allied Managed Care Inc. (AMC) ▪ *Utilization Review Director (2022 - Present)* ▪ *Utilization Review Manager (2014 – 2021)* ▪ *Utilization Review Supervisor (2008 – 2014)*
2007 – 2008	InterMED Cost Containment Services ▪ *Utilization Review Nurse*
2006 – 2007	Oakdale Heights of Roseville ▪ *Resident Care Director*
2005 – 2005	Sunbridge Brittany Care Center ▪ *Licensed Vocational Nurse/Medicare Unit Coordinator*
2004 – 2004	Capital Allergy and Respiratory Disease ▪ *Licensed Vocational Nurse*

Shannon Buelna, LVN
Utilization Review Manager

2003 – 2004 Sunbridge Brittany Care Center
- *Licensed Vocational Nurse*

EDUCATION / LICENSES / TRAINING / CERTIFICATES

- Colorado State University – Global Campus: Bachelor of Science, Healthcare Administration and Management
- Western Career College, Vocational Nursing Program
- Licensed Vocational Nurse, 2003
- Intravenous/Blood Withdrawal Certified
- Residential Care Facilities for the Elderly – Administrator

EXHIBIT 6 –
Cost Proposal

Exhibit 6 – Cost Proposal

Acclamation Insurance Management Services, Inc., (AIMS) and Allied Managed Care, Inc. (AMC)

Proposed Cost Proposal

For

Cost Proposal

For all services offered in your written proposal, complete the appropriate cost proposal worksheet in Attachment I A, B, and/or C of this RFP and include them in a separate section of your written proposal. In addition, indicate on this cost proposal a schedule of rates for additional related services, if any, which the City may consider, at its sole option.

Please see our detailed Proposed Annual Fee for Services below.

Claims Administration Fees: Flat annual fee for service

Acclamation Insurance Management Services, Inc. (AIMS) has included the completed cost proposal worksheets: Attachments I A, I B and IC as requested by the City of Richmond (City).

The following is offered as supporting documentation of our cost proposal.

AIMS proposes a "flat annual fee" for the Workers' Compensation Third Party Administration Services which includes the handling of all current open claims, new indemnity claims, and new medical only claims during the life of the contract. A flat annual fee, as opposed to the "per-claim or broken down fees", will provide a fixed and predictable budget item for the City. This flat annual fee eliminates the time and expense required to audit the per-claim fee or other project cost estimates which varies month-to-month.

In calculating the estimated flat annual rate for Claims Administration, AIMS first determines what the appropriate staffing requirements are in order to perform the required services. The required staffing is consistent with the requirements in the City's RFP. The estimated staffing is then used to calculate the total staffing cost associated with the City's program. The total staffing cost is then used to determine the total operating costs related to the program. Lastly, AIMS corporate overhead and a reasonable profit are added to the total operating costs to determine a reasonable claims administration fee for the program.

AIMS proposes the use of Allied Managed Care, Inc. (AMC) to provide any necessary medical cost containment services except for Nurse Case Management Services.

AIMS estimates of the required claims staffing is calculated with the use of our recommended managed care strategic partner, AMC, for medical cost containment services. As a result of significant electronic interfaces with AMC, AIMS typically requires less staff, on a bundled basis, to complete the required work and, therefore, the fees and costs are typically lower on a bundled basis since there is more efficiency built-in for the claim handlers. AIMS has included the AMC fees for all Managed Care Cost Containment Services below.

The pricing below is based upon the staffing requirements as set forth in the subject RFP and any Addendum(s) or additional information provided:

- **Staffing Requirements:**
  - **Dedicated Sr. Examiner**
  - **Dedicated Sr. Examiner**
  - **Designated Future Medical Examiner**
  - **Designated Claims Assistant**

The City's AIMS staffing will have the appropriate claims supervision and Claims Manager to oversee the partially dedicated claims unit and program. In addition, the necessary corporate management, claims management/supervision, IT management, clerical staff and other support staff will be assigned to the City's program.

This fee is premised on, and in reliance on, the staffing requirements as set forth in the RFP or related information provided. Should the City of Richmond require additional staffing, then both AIMS and the City will negotiate, in good faith, a reasonable fee adjustment based on any revised required staffing.

Claims Administration

AIMS Proposed Fees:

Year One	**$ 610,000.00**
Year Two	**$ 628,300.00***
Year Three	**$ 647,147.00***
Total 3 Year Fixed Sum	**$ 1,885,447.00**

** Annual cost of living adjustment of 3.0%*

Should AIMS be selected for consideration to be the Claims Administration service provider for the City's program then AIMS is open to negotiating a "best and final" fee arrangement that is based on any updated staffing and/or updated service requirements that will result in a fee arrangement mutually beneficial to both the City and AIMS.

The total annual flat fee proposed above contemplates handling all claims activity in a 12-month period (claims already open at the beginning of the 12-month term and any new claims reported during the 12-month term). The annual fee will be invoiced in 12 equal monthly amounts in arrears. The flat annual fees quoted above include all the services detailed in this RFP proposal response including, but not limited to, the following services:

• Program Implementation	Included
• All Claims Management Functions (currently open & new claims)	Included
• Client RMIS Access	Included
• Data Management	Included
• Claim File Storage	Included
• Claim File Retrieval	Included
• Account Management	Included
• Claim System Reporting	Included
• Public Self-Insurer's Annual Report	Included
• OSHA Reporting Assistance	Included

• Prepare Federal form 1099 notices	Included
• Custom AIMS "dashboard"	Included
• Web Site Access (on-line)	Included
• Detailed Stewardship Reports/Presentations	Included
• Training Participation	Included
• MMSEA Reporting	Included*

**Costs associated with Medicare Set-Aside analysis and submission or Medicare Conditional Lien negotiations are Allocated expenses and paid off of the*

Program Implementation, including Data Conversion

Generally, there is a one-time, direct pass through, fee for data conversion and transfer. This fee will generally not exceed $15,000.00 per source entity. However, since the City is a current Client of AIMS there will be no data conversion and transfer fees.

Program Implementation is included in the Flat Annual Fee.

Hourly rate for customization of reports and special reports requests

Customization reports: Most **ad-hoc report** requests can be completed by our Data Delivery Services (DDS) team without any additional charge to the Client. Should the City have a highly specialized report that requires special programming of the system then DDS will secure and provide an estimate of the fees to complete the request and seek approval from our Client before proceeding. A typical hourly rate for these customized reports is approximately $250.00. All specialized report fees are on a "pass- through" basis.

Allocated expenses not covered under the base price

Allocated Loss Adjustment Expenses

In the normal course of administering workers' compensation claims there will be additional fees for services provided by non-affiliated, Client approved, service providers that are paid off of and allocated to the respective claims file. These Allocated Loss Adjustment Expenses (ALAE) or adjustment expenses are linked directly to the processing of a specific claim. ALAE is included as part to the expense reserves, along with loss reserves, on a claims file and are included in the calculation for the funding of the loss trust fund in order to pay claims, both

losses and expenses, in a timely manner. Allocated expenses would normally include, but not be limited to, the following:

- Fees of outside counsel for claims in suit, coverage opinions and litigation and for representation at hearings or pretrial conferences;
- Fees for court reporters;
- All court cost, court fees, and court expenses;
- Fees for service of process;
- Costs of undercover operatives and detectives;
- Costs for employing experts for the preparation of maps, professional photographs, accounting, chemical or physical analysis, diagrams;
- Costs for employing experts for the advice, opinions or testimony concerning claims under investigation or in litigation or for which a declaratory judgment is sought;
- Costs for independent medical examination or evaluation for rehabilitation;
- Cost of legal transcripts of testimony taken at coroner's inquests, criminal or civil proceedings;
- Cost for copies of any public records or medical records;
- Costs of depositions and court reported or recorded statements;
- Non-AIMS Costs and expenses of subrogation;
- Costs of engineers, handwriting experts or any other type of expert used in the preparation of litigation or used on a one-time basis to resolve disputes;
- Witness fees and travel expenses;
- Costs of photographers and photocopy services;
- Costs of appraisal fees and expenses (not included in flat fee or performed by others); Costs of indexing claimants;
- Services performed outside our normal geographical regions;
- Costs of outside investigation, signed or recorded statements;
- Out of the ordinary non-AIMS expenses incurred in connection with an individual claim or requiring meeting with the Client;
- Costs associated with Medicare Set-Aside analysis and submission or Medicare Conditional Lien negotiation;
- Any other extraordinary services performed by AIMS at the Client's request;
- Investigation or possible fraud, including Special Investigations Unit services and related expenses;
- Any other similar cost, fee or expense reasonably charged to the investigation, negotiation, settlement or defense of a claim or loss or to the protection or perfection of the subrogation rights of the Client.

Performance-Based Compensation Alternatives: The City is willing to consider performance-based compensation alternatives. If offering such alternatives, please outline the options below and indicate the standards that would used to qualify:

AIMS is open to discussing and including the performance measures that are important to the City. As such, the following is general in nature as AIMS believes it is important to meet with the City to clearly develop and understand the performance guarantees.

AIMS has Client specific performance clauses with several of our Clients. Mutually beneficial performance and financial incentives include bonuses for above average results and reduced fees for below average performance. Determination of performance can be evaluated by random sample audits and/or information obtained via data collected and reported by our claim system and/or bill review and/or utilization review software. Items have, in the past included topics such as staffing levels, closing ratios, penalties, timeliness of forwarding litigation files, timeliness of determining compensability, bill review savings, fee increases for subrogation recoveries, and fee increases for facilitation of Return to Work processes.

Sample Performance Clause: *The following incentives are based on the score of an annual audit conducted by our Client. We are given an opportunity to discuss and review the audit with our Client. If AIMS is able to obtain a score between 85-89%, AIMS receives 1.5% of the Base Fee back, 90-94% is 3.0% and 95% or over is 4.5%. In addition, if we are able to score between 80-84%, then we are revenue neutral, 75-79% a negative 1.5% and anything less than 75% is a negative 4.5% of base fee.*

Medical Cost Containment Services utilizing Allied Managed Care, Inc. (AMC)

Bill Review: Flat fee bill

Medical Bill Review/PPO:

Official Medical Fee Schedule (OMFS) Review:

Flat fee per bill:

$7.50 per bill (flat rate per bill) plus PPO access fee (see below)

The following is included (at no additional charge):

- Full Duplicates
- Appeals
- Initial Setup
- Technology Fees for Interface
- Client Training
- Re-evaluation/Provider Inquiries
- Expert Testimony in Defense of Reviews
- Electronic Data Interface and On-line Access
- Courier Service

PPO fee for savings below fee schedule:

PPO Network Access Fee:

Anthem Blue Cross – CA	26%
First Health / Coventry	24%
Procura	22%
PRIME	19%
InterPlan	18%
ClarisPointe	18%
ASI Flex	18%

Specialty Bill Review:

Negotiation of Non-OMFS and Line-Item Audit bills, including Inpatient/Outpatient Hospital bills (non-PPO charges):

10% of Savings capped at a maximum of $5,000.00.

Electronic billing:

Electronic and Standardized Billing Regulations: $1.00 per bill.

Utilization Review: Flat fee for UR provided by doctor, flat fee for UR provided by nurse

Utilization Review (UR)

a) **Nurse Review:**

$95.00 per UR (nurse) Referral. This includes unlimited treatment requests and reviews per referral.

b) **Physician Review:**

$225.00 per Peer Review Referral. This includes unlimited treatment requests and reviews per referral.

The following is included in the above fees:

- Initial set-up at the time of award of contract
- Customized Special Account Instructions
- Documentation letters post UR and Peer Review
- Technology Fees for interface
- Production Reports & Metrics
- Consultation with AMC's Medical Director
- Client Training

Nurse Case Management: Hourly fee for telephonic case management, hourly fee for field case management

Medical Management (Nurse Case Management)

a) **Telephonic Case Management:**

$95.00 per hour

b) **Field Case Management:**

$110.00 per hour*

**Travel for Field Case Management (On-Site) services will be charged at the Internal Revenue Service approved rate for mileage at the time the mileage is incurred.*

Allied Managed Care Service Entity Medical Provider Network (MPN)

It is our understanding that the City currently does not utilize a medical provider network (MPN) at this time. The following information is provided to the City for their consideration.

AIMS will work with the City, if they so desire, to establish an MPN, based upon the City's needs. AMC can install the MPN as the primary network. The following networks are available for secondary placement:

- Procura
- PRIME
- InterPlan
- ClarisPointe
- ASI Flex

AMC offers custom provider networks, both MPN and PPO, to be used exclusively by our individual Clients. These workers' compensation specific networks incorporate the medical providers with extensive, specialized experience in dealing with injuries incurred at the work place or job site.

SB 863 changes now allow for "Service Entity" MPN certification. On March 11, 2015 AMC received approval from Department of Industrial Relations, Division of Workers' Compensation Medical Unit for the AMC MPN (MPN Identification #2360). This approval is valid for a period of four (4) years.

AMC has been approved by the Department of Workers' Compensation (DWC) as a Services Entity MPN. What this means to a Client is that they can now join the AMC MPN without having to file an MPN on their own and take on all the regulatory requirements as an Employer.

We hope that the City takes advantage of this great opportunity to join the AMC MPN. Some of the benefits would include:

- Medical Control for the Life of the Claim, if employee has not predesigned a physician.
- Elimination of providers that over-utilize narcotics or medical treatment.
- Quality Care from MPN providers.
- Per DWC reduced medical care and reduced lost time.
- Referral to specialists within MPN
- Quality Care monitoring through MPN.
- Medical Access Assistant to assist employees from 7am to 8pm Monday-Saturday.
- Bottom-line reduced medical costs for higher quality medical care.

These workers' compensation specific networks incorporate the medical providers with extensive, specialized experience in dealing with injuries incurred at the work place or job site. Employees receive the necessary treatment to relieve and resolve the effects of a work related injury.

The MPN includes Certification from the State of California and Enrollment Notices to all Employees complete monitoring of the MPN for State Compliance and reporting with toll free access/assistance for Employers and Injured Employees and all services listed below. This also includes the continued monitoring of the Enrollment Process for New Hires.

Available Services:

- Assistance with creating MPN enrollment notices
- MPN Application / Certification from State
- On-line provider locater
- 10% change monitoring
- Toll Free Network Access Assistance to help locate providers
- Support for Network & Employer provided
- MPN roll-out meetings
- Reporting

We will work collaboratively with our Clients to ensure a smooth transition, including comparing the current MPN to determine which providers are already in our available Networks. Network development can recruit, credential, and contract any specific qualified providers to participate in the City's provider network.

In addition to the MPN, AMC has an ever growing list of PPOs to offer and will work with our Client to determine the best PPOs for our Client's program. Our broad menu of network relationships is designed to offer our Clients the ability to match their own experience with the PPO option that would maximize cost effectiveness. By not being tied to or owning any network affiliation we can provide that expertise and flexibility to our Client for all bill types in all jurisdictions. Additionally, the system allows several ways in which we can maintain and support Client specific contractual discounts.

AMC's Bill Review software identifies PPO and negotiated fee providers by Tax ID Number. AMC can load virtually any PPO or negotiated fee arrangement by individual provider, by Tax ID Number, into the Bill Review software engine for automated

application of discounts. Certain PPO networks are better than others depending on the locations of the providers, type of contracts, specialties of the providers, discounts etc.

Pricing for these services is dependent on the size and complexity of the MPN and will be provided should the City be interested in implementing this valuable cost containment resource. Typical pricing, as a sample only, is as follows:

Allied Managed Care Service Entity Medical Provider Network (MPN)

Fee: $2000.00 per month (estimate only)

The MPN Fee includes access to an already certified DWC MPN and Enrollment Notices to all Employees complete monitoring of the MPN for State Compliance and reporting with toll free access/assistance for Employers and Injured Employees and all services listed below. This also includes the continued monitoring of the Enrollment Process for New Hires.

Included Services:

- Assistance with creating MPN enrollment notices
- MPN Application / Certification from State
- On-line provider locater
- 10% change monitoring
- Toll Free Network Access Assistance to help locate providers
- Support for Network & Employer provided
- MPN roll-out meetings
- Reporting

Please see the below RFP- related Attachments:

- ✓ **Attachment I A - Claims Administration Cost Proposal**
- ✓ **Attachment I B - Bill Review Services Cost Proposal**
- ✓ **Attachment I C - Utilization Review Services Cost Proposal**

End of Cost Proposal

ATTACHMENT I A
CLAIMS ADMINISTRATION COST PROPOSAL

Claims Administration Cost Proposal

Complete and include this cost proposal worksheet if you are proposing workers' compensation claims administration services. Proposals which do not contain this cost proposal may be rejected. If non-company owned vendors are used for any services proposed, attach their proposal to you for such services.

1. Claims Administration Services

Proposed **fixed sum** for Workers' Compensation Claims Administration Services to include assumption of all open claims, new indemnity, new medical only, new first aid, and all future medical claims for the proposed THREE (3) year contract period:

$ 1,885,447.00

Other costs (if any) related to claims administration for the proposed THREE (3) year contract period:

Standard reports: $ -0-

Customized reports: $ -0-

Computer access fee: $ -0-

Data transfer/conversion: $ -0-

Other: $ See Below

(Please specify): **Customization of reports**: Most **ad-hoc report** requests can be completed by our Data Delivery Services (DDS) team without any additional charge to the Client. Should the City have a highly specialized report that requires special programming of the system then DDS will secure and provide an estimate of the fees to complete the request and seek approval from the City before proceeding. A typical hourly rate for these customized reports is approximately $250.00. All specialized report fees are on a "pass- through" basis

2. **Performance-Based Compensation Alternatives:** The City is willing to consider performance-based compensation alternatives. If offering such alternatives, please outline the options below and indicate the standards that would used to qualify:

AIMS is open to discussing and including the performance measures that are important to the City. As such, the following is general in nature as AIMS believes it is important to meet with the City to clearly develop and understand the performance guarantees.

AIMS has Client specific performance clauses with several of our Clients. Mutually beneficial performance and financial incentives include bonuses for above average results and reduced fees for below average performance. Determination of performance can be evaluated by random sample audits and/or information obtained via data collected and reported by our claim system and/or bill review and/or utilization review software. Items have, in the past included topics such as staffing levels, closing ratios, penalties, timeliness of forwarding litigation files, timeliness of determining compensability, bill review savings, fee increases for subrogation recoveries, and fee increases for facilitation of Return to Work processes.

Sample Performance Clause: *The following incentives are based on the score of an annual audit conducted by our Client. We are given an opportunity to discuss and review the audit with our Client. If AIMS is able to obtain a score between 85-89%, AIMS receives 1.5% of the Base Fee back, 90-94% is 3.0% and 95% or over is 4.5%. In addition, if we are able to score between 80-84%, then we are revenue neutral, 75-79% a negative 1.5% and anything less than 75% is a negative 4.5% of base fee.*

Submitted By: Dominic Russo, President & CEO AIMS/AMC

(Firm Name) Acclamation Insurance Management Services, Inc. (AIMS)

(Signature of Individual Authorized to Bind on Behalf of Firm)

ATTACHMENT TB
BILL REVIEW SERVICES COST PROPOSAL

Bill Review Services Cost Proposal

Complete and include this cost proposal worksheet if you are proposing bill review services. Proposals which do not contain this cost proposal may be rejected. If non-company owned vendors are used for any services proposed, attach their proposal to you for such services.

1. Bill Review

Flat fee per bill: $ 7.50 per bill
Specialty Billing Percentage of Savings: 10% Savings
Specialty Billing Maximum Cap: $ 5,000 per bill Maximum Cap

2. Other Services Associated with Bill Review (Specify service and cost, if any:)

The following is included (at no additional charge):

- Full Duplicates
- Appeals
- Initial Setup
- Technology Fees for Interface
- Client Training
- Re-evaluation/provider Inquiries
- Expert Testimony in Defense of Reviews
- Electronic Data Interface and On-line Access
- Courier Service

Submitted By: Dominic Russo, President & CEO AIMS/AMC

(Firm Name) **Acclamation Insurance Management Services, Inc. (AIMS)**

(Signature of Individual Authorized to Bind on Behalf of Firm)

ATTACHMENT TB
BILL REVIEW SERVICES COST PROPOSAL

Utilization Review Services Cost Proposal

Complete and include this cost proposal worksheet if you are proposing utilization review services. Proposals which do not contain this cost proposal may be rejected. If non- company owned vendors are used for any services proposed, attach their proposal to you for such services.

1. **Utilization Review**

   Flat fee per review (nurse): $ 95.00 per request of authorization

   Flat fee per review (Dr. peer review) $ 225.00 per request for authorization

2. **Other Services Associated with Utilization Review (**Specify service and cost, if any:)

The following is included in the above fees:

- Initial set-up at the time of award of contract
- Customized Special Account Instructions
- Documentation letters post UR and Peer Review
- Technology Fees for interface
- Production Reports & Metrics
- Consultation with AMC's Medical Director
- Client Training

Submitted By: Dominic Russo, President & CEO AIMS/AMC

(Firm Name) Acclamation Insurance Management Services, Inc. (AIMS)

(Signature of Individual Authorized to Bind on Behalf of Firm)

ACCLAMATION INSURANCE MANAGEMENT SERVICES

EXHIBIT 7 –

Settlement Authority Request Worksheet

ACCLAMATION INSURANCE MANAGEMENT SERVICES

SETTLEMENT AUTHORITY REQUEST
(CONFIDENTIAL)

To:

RE: EMPLOYEE:
DATE/INJ:
CURRENT AGE:
INJURY TYPE:

EMPLOYER: City of Oxnard
CURRENT EMPLOYEE:
OCCUPATION:
CLAIM #:

DEFENSE ATTORNEY:

TREATING PHYSICIAN: RATING: % =

AME: RATING: % =

PANEL QME: RATING: % =

DEFENSE QME: RATING: % = $

Medicare Set Aside Apply? [Yes] [No]

STIPULATIONS: PAID TO DATE: $ BALANCE: $

Open Future Medical: Yes/No

COMPROMISE & RELEASE:

PD: %, $ PAID TO DATE: $

FUTURE MEDICAL: $

TOTAL: $ PAID TO DATE: $ BALANCE: $

Open Future Medical: [Yes] [No]

COMMENTS:

RECOMMENDATIONS:

CLAIMS EXAMINER:_____ DATE:_____

Supervisor Signature (if needed)

_____ DATE:_____

Client Settlement Request Approved as Recommended:_____

DATE: _____

EXHIBIT 9 –

Scope of Services Detail

Exhibit 9 – Scope of Services Detail

SCOPE OF SERVICES

AIMS senior operating management team is familiar with the "Scope of Work" and as the current vendor has been able to meet this criteria and if selected will continue to fully comply with all requirements as presented in this "Scope of Work".

The TPA all services required to supervise and administer the City's self- insured workers' shall perform compensation claims, and to act as the City's representative in matters relating to the City's obligations under the workers' compensation laws for the State of California.

We have reviewed and will comply with this requirement

Program Administration Needs: The City's Risk Management Division, in the Human Resources Management Department, coordinates all aspects of the workers' compensation program including the management of the TPA and its contract.

We have reviewed and will comply with this requirement

Permanent Disability: As soon as the TPA receives notice of permanent and stationary status, they shall communicate this information to the City so that permanent accommodation consideration can be initiated.

We have reviewed and will comply with this requirement

Fraud Control: The City requires the TPA to aggressively control fraud and pursue restitution in all fraud cases. Risk Management shall be notified of all claims involving potential fraud and initiation of fraud investigation activities.

We have reviewed and will comply with this requirement

Claims Reviews: On-site quarterly claim reviews at the City are required and involve participation by City Department representatives. The TPA is expected to send claim staff to attend claim reviews and be prepared to discuss agendized claims.

We have reviewed and will comply with this requirement

Loss Reporting and Data: The TPA shall provide basic loss reports electronically that detail payments and check runs, claim frequency, paid and incurred costs, annual OSHA reports, 1099's and the annual SIP report. In addition, the City may need on occasion to obtain other reports for various purposes including, but not limited to, actuarial studies, audits, program and departmental analysis. The City retains the right to select the risk management information system. The TPA shall not change the RIMS without advance written notice to the City and consent by the City.

We have reviewed and will comply with this requirement.

Please see Exhibit 10 – AIMS Sample Claims Reports

Claims Personnel: The City maintains the right to interview and review evidence of work experience of all personnel to be assigned to its account and to approve such personnel. The City shall have a right to request a change of designated account staff. The claims supervisor and senior claims examiner shall possess a self-insured certification. A minimum of 5 years experience shall be required of the claims supervisor, senior claims examiner, and claims examiner.

We have reviewed and will comply with this requirement.

Please see Exhibit 4 – Team Resumes

The TPA will input all new claim reports within 24 hours of receipt.

We have reviewed and will comply with this requirement.

The City and/or the excess carrier may conduct claims performance audits to measure the TPA's performance and compliance with claims administration standard's and requirements. The TPA shall provide the results of the SAS70 audit compliance report on an annual basis.

We have reviewed and will comply with this requirement.

Please see Exhibit 11 – SSAE 18 Reports SOC 1 and SOC2 Reports (CONFIDENTIAL)

Excess Carrier: Report on all potential excess carrier claims as required to the applicable excess carrier. Provide to the City a copy of each report and pursue, when appropriate, excess reimbursements from the carrier. Maintain records on excess re-insurers and reimbursements on behalf of the City. Comply with all State mandated reporting requirements (SIP, DWC, OSHA log, etc.)

We have reviewed and will comply with this requirement.

Settlement Authorization: Prepare and submit settlement authorization request for approval by the City prior to initiating settlement negotiations. The City may, at its discretion, grant limited authority to the TPA to resolve minor claims; however, settlement authorization request forms must still be submitted to the City. Settlements involving payments of over ten thousand dollars ($10,000) require City Council approval. Provide at least 35 days advance notice of settlement authorization requests for settlement amounts over ten thousand dollars ($10,000).

We have reviewed and will comply with this requirement.

The TPA will provide documentation and information as needed to enable the City to effectively coordinate return to work and the ADA interactive process.

We have reviewed and will comply with this requirement.

The TPA will maintain an electronic and/or paper file on each claim.

We have reviewed and will comply with this requirement.

The TPA will provide the City with updates and information on changes or proposed changes in statutes, rules, and regulations affecting the City's responsibility under a self-insured workers' compensation program.

We have reviewed and will comply with this requirement.

AIMS prides itself on providing the kind of pro-active Client service seldom seen in our industry. From in-person meetings with the City to year-end performance reporting on the program development, we are always available to go the extra step.

AIMS has developed a variety of training programs for employers that can be customized and incorporated into the Client's own training programs. These programs are overseen by our Vice President Workers' Compensation, Cheryl Agee, and our Senior Vice President Operations, Lynn Cavalcanti. Cheryl manages a team of staff who provide training on a wide range of topics including; California Education Code Benefits, "Workers' Comp 101", legislative changes, fraud prevention, return-to-work (RTW), and State laws, etc. When requested, training sessions on proper reporting, new case law or changes in the methodology set by the State of California on the delivery of workers' compensation services training is provided as an integral part of our value-added partnership. Training sessions are held at our offices, Client locations or other specific areas designed to accommodate a number of our Clients. This service comes at no

additional charge.

Please see Exhibit 2 – Sample Legislative Advocate Report

Claims Administration Services

The AIMS senior operating management team has reviewed the Claims Administration Scope of Work outlined detail. Our team fully complies with all requirements as presented in the Scope of Work. Please see the Claims Administration response under the Specific submittal Requirements section for complete details.

A. Determine liability for claimed injuries and illnesses on a timely basis and in accordance with the California Labor Code.

We have reviewed and will comply with this requirement.

AIMS utilizes industry best practice standards, in compliance and accordance with the California Labor Code, for workers' compensation claims management. It is AIMS protocol for the Examiner to review and investigate the claim for compensability upon claim assignment. This includes the initiation of 3-point contact within 24 hours of receipt of new workers' compensation indemnity claims. Examiners evaluate all claims for Arising out of Employment (AOE) / Course of Employment (COE), delay, denial, subrogation, or referral for investigation of issues surrounding injury. Examiners request all required documentation from Doctors, Client, and Injured Worker. All claims which are to be denied or delayed, pending a compensability decision, shall be done in keeping with all applicable statutory rules and regulations (and/or case law). All denials and delays are approved by the team Supervisor. Authority to delay or deny a claim is first obtained from the City, unless express written authority for this purpose is granted to AIMS.

All questionable claims are investigated in a prompt, thorough, and legal manner to determine compensability or to validate issues in question. The Examiner identifies the need for investigation and will refer the case for same within three (3) days from receipt of claim, or knowledge of questionable issues which give rise to the need for investigation.

The City's authorization is first obtained before initiating any field investigation. This authorization is documented in the notepad section of the claims file.
AIMS protocol is for all payments to be made in a timely and comprehensive fashion in conformance with the Official Medical Fee Schedule (OMFS), Labor Code sec. 5307.1 and sections 9789.10 et seq. of Title 8, California Code of Regulations

B. Determine eligibility for and authorize payment of medical and indemnity benefits

on a timely basis.

We have reviewed and will comply with this requirement.

Paying appropriate and timely benefits is critical in our business. AIMS has multiple levels of assurances in this regard. Before a payment is issued, it is verified for appropriateness, accuracy, and reserve adequacy. When applicable, minimum statutory requirements are adhered to or exceeded. All payments are listed in each file, and distinguished by the following basic categories: Indemnity, Medical, Legal/Allocated, and Vocational Rehabilitation. AIMS policy is all payment documentation is contained within the claims file.

C. Review, compute, and, after approval by the City, pay all informal ratings, findings and awards, and settlements; arrange for informal disability ratings whenever possible to avoid unnecessary litigation.

We have reviewed and will comply with this requirement.

Once a claim has reached the point of serious settlement negotiations, we collect all pertinent data and present it to authorized City personnel in a Settlement Authorization Request. Included in our Settlement Authorization Request is the reserve documentation indicating the adequacy of the reserves for eventual settlement offers, a summary of paid-to-date amounts, any disability ratings, medical reports, and a synopsis written by the handling Claims Examiner. The synopsis includes a complete risk assessment with any available alternative options authored by defense counsel (if applicable). The Settlement Authorization Request is approved by the Claims Manager and/or Supervisor and presented to the City in a timely fashion and in a format customized to meet the needs of the City. AIMS does not enter into any settlement negotiations without prior approval from the authorized City representative.

Additional focus and coordination is provided for those claims within the City's ADR/Carve out Program; as the goal and objective of is to provide expedited claim resolution – up to and including claim settlement.

All awards are processed for payment within the statutory requirements or within fourteen (14) calendar days, whichever is less. All appropriate accrued interest is included in the award payment unless the approved award has had the interest waived by the parties and the court in the settlement document.

Please see Exhibit 7 – Settlement Authority Request Worksheet

D. Pay any and all penalties due in accordance with the California Labor Code. Such penalties shall be paid by the claims administrator with liability for the action determined by the record unless such penalties were incurred as a result of the City's action or

inaction.

We have reviewed and will comply with this requirement.

AIMS has a robust **Penalty Prevention Process**, which is augmented by our ability to track incoming documents and scheduled benefit payments. While it is never our intent to incur penalties, in the rare instances when they happen, AIMS immediately corrects the issue and makes the penalty payment. At the same time the payment is made, the Claims Team produces a Penalty Prevention Form which is circulated inside the appropriate departments at Corporate for reimbursement to the Client. It is always our desire to take notice of any penalties rather than being made aware of them through outside sources. AIMS understands and takes very seriously the fact that these payments are not the fault of the Client and quickly works with our Accounting Department to refund these to the Client Trust Fund. Careful reconciliation of these payments occurs within the Accounting Department and the Claims Management System so all parties are aware of the occurrence and reimbursement schedule.

E. Establish files containing medical and factual information on each reported claim, together with complete accounting records and maintain in accordance with statutory time requirements.

We have reviewed and will comply with this requirement.

Captured Claim File Data: A file is established for each reported claim and all claims-related documents are stored electronically, retrievable by claim number. The electronic file can be sorted and filtered by all of the index fields including date ranges and types of documents.

All files include pertinent information (such as litigated court case number, cross-referencing, future medical award, "closed" and date closed, etc.).

All electronic files are include the following documents:

- **Correspondence** (all non-medical, non-rehabilitation, non-payment documents including the Employer's First Report, letters file memos, reserve analysis, legal correspondence, data input sheets, index returns, etc.).
- **Legal Information (all information relating to the litigation of the claim).**
- **Medical** (all medical reports, notes, disability notes signed by medical personnel, except subpoenaed records, photo-copied records).
- **Payment documentation** (such as approved bills, invoices, etc.).

Paperless Solution: AIMS has partnered with a global leader in IT solutions, to provide a paperless solution that includes document-based business process management (BPM) with ease of usage and accessibility. The AIMS paperless system (AX) is directly integrated with the claims system. AIMS Clients have appropriate access to the paperless documents through the claim system. When a claim is open in the claims system the City staff select a hotkey that opens all associated files for the requested

claim. Our paperless environment also has the ability to provide documents to the City by searching by date, physician name and/or medical report type, pulling the data across all claims and mail received. This eliminates the need to access each individual claim file to review reports.

All claims related documents are centrally captured, indexed, and stored in the paperless system. The paperless system has customized key index values to simplify file organization and search ability. A customized global workflow process has been created to eliminate the possible loss of documents, the duplication of documents, and the accuracy of filing. Customized business workflow processes are attached to each document type (medical, legal, bills, etc.) to streamline activities required by Claims Examiners during the claims process. Documents requiring time sensitive processing have built-in triggers and management oversight flagging to ensure expedited handling of those documents.

The paperless system is separate and distinct from the claim system. AIMS' paperless solution is built on a separate database and storage platform that is virtualized for redundancy and high availability. All documents are accessible through a separate interface from AIMS' claim system and can be opened simultaneously.

F. Prepare, file, and maintain all information and reports as required by the State of California, Department of Self-Insurance.

We have reviewed and will comply with this requirement.
Claims are entered into the claim management system within one (1) day from receipt of the first notice of claim and all files are maintained on a 30-day diary by the assigned Examiner to ensure the claim is progressing as expected and that all required information has been received and or the request for the information is documented in the claim file. The standing plan of action is reviewed at each diary date and updated accordingly.

The City is kept appraised of the status of their claims via a claims status report created and sent every 90-days when the Plan of Action Review has been completed.

All statutory State and Federal reporting requirements are prepared in a timely manner, in accordance with the required specifications of the regulating agency. Annual reports to the State regarding claims and financial experience are prepared on behalf of the Client in accordance with the rules and regulations of the jurisdiction.

G. Provide the City with information and recommendations for implementation strategies for changes or proposed changes in statutes, rules and regulations affecting the City under the California Labor Code for workers' compensation.

We have reviewed and will comply with this requirement.

AIMS prides itself on providing the kind of pro-active Client service seldom seen in our industry. From in-person meetings with the City to year-end performance reporting on the program development, we are always available to go the extra step.

AIMS has developed a variety of training programs for employers that can be customized and incorporated into the Client's own training programs. These programs are overseen by our Vice President Workers' Compensation, Cheryl Agee, and our Senior Vice President Operations, Lynn Cavalcanti. Cheryl manages a team of staff who provide training on a wide range of topics including; California Education Code Benefits, "Workers' Comp 101", legislative changes, fraud prevention, return-to-work (RTW), and State laws, etc. When requested, training sessions on proper reporting, new case law or changes in the methodology set by the State of California on the delivery of workers' compensation services training is provided as an integral part of our value-added partnership. Training sessions are held at our offices, Client locations or other specific areas designed to accommodate a number of our Clients. This service comes at no additional charge.

Please see Exhibit 2 – Sample Legislative Advocate Report

H. Review with the Citythe program's progress, including identification of problem areas and conduct periodic root cause analysis and recommended solutions to reduce claims cost and attend monthly regularly scheduled meetings required by the City relative to the workers' compensation program.

We have reviewed and will comply with this requirement.

As a true partner with the City, AIMS attends monthly department meetings and litigation meetings where all high profile and claims on disability are reviewed and discussed. It is important for the department heads of the City to know and understand their current inventory of employees receiving disability and/or nearing finalization of their claims where permanent restrictions are likely. Key claims are discussed at these meetings to insure that all parties (Risk Management, Department & AIMS) are in agreement with how the claim should proceed and what the ultimate claim resolution goal is. These meetings are key to the success of this program and AIMS respects and admires the City for continuously conducting them.

Typically, monthly meetings include a discussion of:

- Current case status, reserves, and resolution plan
- Functioning of the workers' compensation program
- Develop coordinated plans for specific claims handling
- Cost savings plans
- Coordinate plans for returning employees to work

In addition, AIMS advises the City of individual claim development(s) in multiple formats

(written notifications are customized on an individual Client basis) which include but not limited to:

- Claim Status Report Forms
- Electronic Mail Updates
- Letter - Narrative
- Customized Reports

The program analysis we provide presents hard data to benchmark results and determine strategies to improve and optimize the program created specifically for the City. Also planned is reports on the outcomes of the ADR/Carve-Out Program implemented early this year. AIMS captures key events, which are directly related to the ADR Program so that analysis and benchmarking can be done of the outcomes and cost savings. Samples of previous benchmarking reports have been included in the noted exhibit.

Please see Exhibit 10 – AIMS Sample Claims Reports

I. Arrange for and supervise all necessary investigations to determine eligibility for compensation benefits and liability of negligent third parties.

We have reviewed and will comply with this requirement.

As indicated previously, it is AIMS protocol for the Examiner to review and investigate the claim for compensability upon claim assignment. This includes the initiation of 3-point contact within 24 hours of receipt of new workers' compensation indemnity claims. Examiners evaluate all claims for Arising out of Employment (AOE) / Course of Employment (COE), delay, denial, subrogation, or referral for investigation of issues surrounding injury. Examiners request all required documentation from Doctors, Client, and Injured Worker. All claims which are to be denied or delayed, pending a compensability decision, shall be done in keeping with all applicable statutory rules and regulations (and/or case law). All denials and delays are approved by the team Supervisor. Authority to delay or deny a claim is first obtained from the City, unless express written authority for this purpose is granted to AIMS.

All questionable claims are investigated in a prompt, thorough, and legal manner to determine compensability or to validate issues in question. The Examiner identifies the need for investigation and will refer the case for same within three (3) days from receipt of claim, or knowledge of questionable issues which give rise to the need for investigation.

The City's authorization is first obtained before initiating any field investigation. This authorization is documented in the notepad section of the claims file.

In addition, AIMS Claims Examiners understand they have the responsibility to review

each claim for possible subrogation potential. Any file which indicates the possibility of subrogation is forwarded to a Claims Supervisor for review to determine if further investigation is required. When authorized by our Client, consultation with AIMS liability specialists to evaluate the strengths and weaknesses of the subrogation will take place.

AIMS will review and identify the cause of the accident for each new claim received and AIMS assigned Claims Examiner will serve as the main subrogation "adjuster". Notice of third party credit recovery is sent out once the relevant party is identified. A notice letter is also sent out to the injured worker. ***A diary for the statute of limitation is set as a backup and the file is reviewed online in the maintained diary for subsequent follow up.***

Upon receipt of the recovery, the adjuster will forward the check with a cover letter indicating the amount of the recovery to be returned to each department.

Some of the points considered may include, but not be limited to injured worker was injured as a result of:

- Injuries away from employer's premises
- A motor vehicle accident
- An assault
- Malfunction of a tool or piece of equipment
- Use of a type of machinery
- Negligence of any other person
- Animal bite

In addition:

- It shall be the responsibility of the Claims Examiner to periodically request a status report from the attorney who is protecting the third party interests, or from the attorney who has filed a lien or intervening petition on behalf of our Client.
- Our Clients will be advised at least semi-annually regarding our efforts to recover moneys which have previously been paid.
- Determination shall be made if Client has other damages to recover. Prior to entering into a recovery agreement, approval of the agreement should be given by our Client. This will protect our Client's interest in recovery of all expenses, including damage to company automobiles, etc., as opposed to simple recovery of workers' compensation costs.
- Upon receipt of the check or checks from the responsible third party or parties, these moneys should be made payable to our Client and credited to the workers' compensation file in the appropriate category.
- In the event where a Police Officer is assaulted by a suspect who is later convicted of the crime and is incarcerated, the Claims Examiner will attempt to pursue

recovery as a condition of the suspect's probation. This arrangement will be made with the local District Attorney's office.

Outside Investigation:

1. All claims requiring an investigation shall be documented as such in the claim file, with an explanation of the issues, the reasons for the investigation, and the objective of the investigation.
2. All investigative assignments (either oral or written) shall be documented by completion of the approved Investigation Assignment Sheet. The assignment will be documented in the claims system.
3. Unless contractually specified otherwise, all investigative assignments shall have the prior approval of the Client.
4. The Examiner or his/her designee(s) shall monitor the results produced by the investigator(s) with the following criteria:
    - Quality of the report
    - Turnaround time
    - Cost
    - The ability to testify or support the findings in court

Sub-rosa:

- Sub-rosa is designed to develop evidence to verify unsubstantiated facts or activities of claimants. Initial report from investigator is to be received within 15 days of assignment. Subsequent Reports should be received from the investigator no less than every 30 days.
- All surveillance assignments should include the precise type of surveillance required with a specific time limitation for the assignment (a maximum of 2-3 days is recommended for the initial authorization).

Subrogation:

- AIMS will pursue recovery on behalf of our Clients from any responsible third party causing a workers' compensation claim. Examiners and Supervisors have the responsibility to review each claim for possible subrogation potential. Our attempts to recover will be based on the merits of successful recovery versus the hazards and delays of litigation.
- Any responsible third party will be notified in a general form letter within 30 days following a decision to pursue recovery. Particular attention will be paid to any applicable Statutes of Limitation which might affect the ability to recover.
- As long as there is subrogation potential, the file shall be kept in an active status with appropriate diary dates.

- The Examiner will pursue recovery. If it is determined that a Subrogation Attorney is needed, the Examiner will discuss and request authorization for the referral with the City.
- It is the responsibility of the Examiner to periodically request a status report from the attorney who is protecting the third party interests, or from the attorney who has filed a lien or intervening petition on behalf of our Client.
- The City will be advised at least semi-annually regarding our efforts to recover money which has previously been paid.
- Determination will be made if Client has other damages to recover. Prior to entering into a recovery agreement, approval of the agreement should be given by the Client. This will protect the Client's interest in recovery of all expenses, including damage to company automobiles, etc., as opposed to simple recovery of workers' compensation costs.
- In a situation where a Police Officer is assaulted by a suspect who is later convicted of the crime and is incarcerated, the Examiner will attempt to pursue recovery as a condition of the suspect's probation. This arrangement will be made with the local District Attorney's office.

In addition, monthly statistics are maintained to determine the number of assignments made and to whom they were assigned.

J. Establish procedures to support the payment of all benefits and allocated expenses together with appropriate documentation necessary to reconcile a trust fund checking account provided by the City.

We have reviewed and will comply with this requirement.

AIMS has extensive expertise establishing Workers' Compensation Trust Fund accounts for our Clients. AIMS Claims Manager will work with the Client to coordinate Client trust funds/checking accounts to ensure accuracy and appropriate funding levels. The Claims Manager function includes providing weekly/monthly check registers directly to Clients.

AIMS established procedures support the payment of all benefits and allocated expenses together with appropriate documentation necessary to reconcile a trust fund checking account provided by the City. All payment requests shall be made with the necessary documentation to allow for an audit trail.

Banking is managed from a separate and distinct division at our headquarters; thus facilitating additional fund management oversight, security, and monitoring.

A monthly reconciliation report is provided to the City detailing trust account activity. The detailed accounting includes the date and check number of all benefits and allocated loss payments. All payment requests are made with the necessary documentation to allow for

an audit trail.

The cost for this service is included in our fees.

Please see Exhibit 6 – Cost Proposal

K. Sponsor and pay for a membership in the nationwide Index System on the City's behalf; submit all claims to the Index System as regular practice.

We have reviewed and will comply with this requirement.

All indemnity claims are indexed. AIMS and other organizations submit tens of millions of reports on individual insurance claims to the Insurance Service Office (ISO). ISO stores those reports in a single database that helps insurers, self-insurers, law enforcement agencies, and state fraud bureaus detect and prevent fraud, evaluate risk, and process meritorious claims. The system furnishes essential data for researching prior-loss histories, identifying claims patterns, and detecting suspect claims.

AIMS will re-index as frequently as the City requires and when claim facts indicate that other claims may exist for which more information is needed.

L. Provide (at no cost to the City) informational pamphlets in appropriate languages to employees as required by the State of California relative to their workers' compensation benefits.

We have reviewed and will comply with this requirement.
AIMS provides the City with Claim Reporting Kits, which include the following forms and information:

- Welcome Letter
- Employers Report of Work Injury or Illness (5020)
- Employee's Claim Form (DWC1)
- Work Injury posters
- Informational pamphlets about AIMS and the claims team
- Instructions for reporting claims

M. Refer litigated cases to attorneys approved by the City for the purpose of defending the City's interest before the Workers' Compensation Appeals Board and courts of law.

We have reviewed and will comply with this requirement.
AIMS works with the City's approved panel of defense firms/attorneys and establishes the agreed upon legal defense panel for the City, which includes referrals to a defense attorney when approved by the City.

When a decision to refer to defense counsel has been made, the Claims Examiner sends a narrative letter to the attorney with an outline of the case, along with the issues and clear directions for further handling by the attorney. The Claims Examiner remains actively involved in the claim and performs as much of the routing handling as possible on these cases. Once a claim has been referred to defense counsel, the Claims Examiner will continue to oversee all activity on the claim, direct all legal activity and monitor performance in accordance with the Client's criteria. This method of active involvement helps mitigate legal costs associated with unnecessary discovery proceedings, helps to gather all required evidence and witnesses as well as arranges expert testimony from the medical community.

N. Attend, where indicated, trials, hearings, arbitrations, rehabilitation hearings and any and all legal proceedings.

We have reviewed and will comply with this requirement.
Yes, within their capabilities and as statutes allow, the AIMS Claims Examiner and/or Supervisor may represent a Client before the Appeals Board of California or judicial body. If the case has a defense attorney assigned, it may not be necessary for the AIMS Claims Examiner to attend the hearing, unless issues call for their attendance.

O. Produce computer generated reports as specified by the City; including, comparison reports with data from similar agencies (anonymous) that may be similar in size or in demographic area.

We have reviewed and will comply with this requirement.

AIMS provides various standard monthly reports and custom reports upon request for each department and division requested by the City. Our system is an extremely powerful data management claims system for both standard and ad hoc report generation. Our web based system, provides convenience and access to real-time and "point in time" financials for generating customized ad hoc reports, multiple program reports for data downloads and monthly loss reports which can be exported into other applications such as PDF or Excel.

Please see Exhibit 10 – AIMS Sample Claims Reports

P. Coordinate Medicare and Medicaid set aside agreements in compliance with Section 111 of the MMSEA including required reporting.

We have reviewed and will comply with this requirement.

AIMS has a formal plan in place to comply with the mandatory reporting requirements of Section 111 ("Medicare Secondary Payer") of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA). AIMS' strategic partner provides Mandatory Insurer Reporting (MIR) Services to our Clients, including State Children's Health Insurance Program (SCHIP) reporting and ensures MSP compliance. Our strategic partner is used for all Qualified Referrals (claim settlements determined to require a Medicare Set Aside (MSA), Claim Settlement Allocation (CSA) and other services related to MSP compliance identified in their fee schedule).

AIMS has selected ExamWorks Clinical Solutions, the nation's most respected Medical Secondary Payer (MSP) compliance leader, to provide MIR Services to our Clients, including SCHIP reporting, and to ensure MSP compliance. ExamWorks Clinical Solutions is AIMS' sole vendor for all Qualified Referrals (claim settlements determined to require a Medicare Set Aside (MSA), Claim Settlement Allocation (CSA) and other services related to Medicare Secondary Payer (MSP) compliance identified in their fee schedule). Also, AIMS continuously evaluates the use of strategic partner services to ensure performance-levels and continued value-added to our Clients.

There are no additional fees to the City for this reporting service

Q. Comply with the PRISM claims adjusting requirements dated 7/1/2011.

We have reviewed and will comply with this requirement.

AIMS has over one-hundred (100) Clients of which approximately 80% are public entities in the State of California. Several of these Clients are contracted with PRISM. AIMS has worked with PRISM for many, many years and AIMS is familiar with their guidelines. AIMS' own protocols mirror those of PRISM and AIMS applies these guidelines to the management of the City's claims.

Bill Review

The AIMS senior operating management team has reviewed the Bill Review Scope of Work outlined detail. Our team fully complies with all requirements as presented in the Scope of Work. Please see the Bill Review response under the Specific submittal Requirements section for complete details.

A. Review all bills in a timely manner for compliance with applicable fee schedules and reduce accordingly, including those that fall outside of a fee schedule or PPO network.

B. Identify and reduce all duplicate billings.

C. Deny charges for all items not required for injury described.

D. Identify all unauthorized charges to ensure billing does not exceed parameters of injured workers' treatment plan.
E. Maintain contracts with effective PPO organizations (including pharmacies), that include providers in the City of Richmond area.
F. Provide reports on a monthly and annual basis outlining bill review activity, savings and costs. Provide ad hoc reports as requested
G. Provide a computer system that interfaces with both the City's workers' compensation TPA and utilization review provider.
H. Handle all provider inquiries regarding bill reductions.

Utilization Review

The AIMS senior operating management team has reviewed the Utilization Review Scope of Work outlined below. As the incumbent, our team fully complies with all requirements as presented in the Scope of Work. Please see the Utilization Review response under the Specific submittal Requirements section for complete details. AIMS is also fully aware and participating in the coordination of medical treatment inside of the City's ADR Program, whose goal is to expedite treatment to impact return to work status and claim resolution. AIMS is working closely with the City to monitor those industrial clinics participating in the ADR Program and provide feedback and suggestions on areas of improvement for delivering medical treatment.

A. Approve or disallow service requests within the applicable time standards and provide medical advice as warranted.
B. Provide timely reports to the City outlining utilization review requests, approvals, denials, and costs/savings.
C. Recommend, for City approval, panels of medical professionals, specialists, and treatment facilities to which injured employees should be referred for long-term or specialized treatment.
D. Provide medical management of all cases to assure cost-effective and appropriate treatment, including assurance that treatment is related to the compensable injury or illness.
E. Arrange for medical/legal opinions in disputed cases, conferring with medical examiners, professional personnel, the City, and legal counsel where indicated.
F. Provide a computer system that interfaces with the selected TPA and bill review service provider.

ACCLAMATION INSURANCE MANAGEMENT SERVICES

EXHIBIT 10 –

AIMS Sample Claims Reports (2 pages per sample)

Sample Loss Run Reports

Claims Activity

As of: 08/29/2019 Activity Period: 08/25/2019 - 08/29/2019

Redacted

LOSS DETAILS | TOTALS

Redacted - Department 1

Claim No / Activity Code	Examiner / LOB	Clmnt Name / Body Part	Status / Type	Loss Date	Knowledge Date	Add Date	Rec'd Date	Last Closed	Last R'open	RTW Date	Juris	ACT. PERIOD Period Paid	ACT. PERIOD Period Incurred	TOTALS Through 8/29/19 Asof Paid	TOTALS Through 8/29/19 TotalReserves
[redacted]	TPalmer	[redacted]	O	2/2/17	2/2/17	2/22/17	2/21/17				CA	0.00	0.00	6,625.03	6,614.97
A	WC	Ears, both	Indemnity												

Redacted - Department 1

Claims Activity : 08/25/2019 - 08/29/2019 **Activity Period** **End of Period**

New Claims:	**0**	**Open w/Payment in Period:**	**0**	**Non-Initial Reserve Change:**	**0**	**Ending Open:**	**1**
Closed:	**0**	**Closed w/Payment in Period:**	**0**	**Returned to Work:**	**0**	**Ending Closed:**	**0**
Reopened:	**0**	**Initial Reserve:**	**0**	**Open, No Financial Activity:**	**0**		

Financial Activity 08/25/2019 thru: 08/29/2019 As Of: 08/29/2019

	INDEMNITY CLAIMS Paid Incurred Reserves	Total
Total	0.00 0.00 0.00	0.00 0.00 0.00

Claim Status Summary as of 08/29/2019

	INDEMNITY	Total
Open	1	1
Total	1	1

[redacted]	[redacted]	[redacted]	O	1/27/16	1/27/16	2/2/16	1/29/16				CA	0.00	0.00	35,444.65	32,622.53
A	WC	Multiple body parts	Indemnity												

1. Closed in Period 2. Reopened in Period 3. Opened in Period 4. Open with Payment 5. Closed with Payment 6. RTW in Period 7. Initial Reserve. 8. Change of Reserve. 9. Denied A. Open w/o Financials

Claims Activity

As of: 08/29/2019 Activity Period: 08/25/2019 - 08/29/2019

Redacted

LOSS DETAILS | TOTALS

Redacted - Department 2

Claim No / Activity Code	Examiner / LOB	Clmnt Name / Body Part	Status Type	Loss Date	Knowledge Date	Add Date	Rec'd Date	Last Closed	Last R'open	RTW Date	Juris	ACT. PERIOD Period Paid	ACT. PERIOD Period Incurred	TOTALS Through 8/29/19 Asof Paid	TOTALS Through 8/29/19 TotalReserves

Redacted - Department 2

Claims Activity : 08/25/2019 - 08/29/2019 **Activity Period** **End of Period**

New Claims:	**0**	**Open w/Payment in Period:**	**0**	**Non-Initial Reserve Change:**	**0**	**Ending Open:**	**1**
Closed:	**0**	**Closed w/Payment in Period:**	**0**	**Returned to Work:**	**0**	**Ending Closed:**	**0**
Reopened:	**0**	**Initial Reserve:**	**0**	**Open, No Financial Activity:**	**0**		

Financial Activity 08/25/2019 thru: 08/29/2019 As Of: 08/29/2019

	INDEMNITY CLAIMS Paid Incurred Reserves	Total
Total	0.00 0.00 0.00	0.00 0.00 0.00

Claim Status Summary as of 08/29/2019

	INDEMNITY	Total
Open	1	1
Total	1	1

1. Closed in Period 2. Reopened in Period 3. Opened in Period 4. Open with Payment 5. Closed with Payment 6. RTW in Period 7. Initial Reserve. 8. Change of Reserve. 9. Denied A. Open w/o Financials

Sample Monthly Reports

Claims Cost Detail

As of: 08/31/2019 Activity Period: 08/01/2019 - 08/31/2019

LOSS DETAILS												TOTALS			
	Status	Loss Age	Dates Loss	Dates Knowledge	Act	Type	Job Code	Juris	Life Med	Days L	Days R	Activity Paid	Paid	Reserves	Incurred
Redacted															
Redacted - Department 1															
Claim #: 16543110	O	58	02/02/2017	02/02/2017	N	Inde	1885C	CA	N	0	0	0.00	6,625.03	6,614.97	13,240.00
Claimant: [redacted]				**Tax ID:** xxx-xx-8[redacted]											
Loss Desc: This claim involves a 58 year old Construction Inspector II who went for an annual physical at work and failed his hearing test. He was referred to CVO for follow up. Delayed claim - Bilateral hearing loss, Hearing loss, cumulative to Ears, both from EXPOSURE LOUD NOISE by Repeated noise at 00:00															
												Indemnity 0.00	0.00	1,740.00	1,740.00
												Medical 0.00	6,459.85	3,540.15	10,000.00
												Other 0.00	165.18	1,334.82	1,500.00
												Total 0.00	6,625.03	6,614.97	13,240.00
										0	0				

Ending Open:	1
Ending Closed:	0
Total:	1

Indemnity	0.00	0.00	1,740.00	1,740.00
Medical	0.00	6,459.85	3,540.15	10,000.00
Other	0.00	165.18	1,334.82	1,500.00
Total	0.00	6,625.03	6,614.97	13,240.00

Claims Cost Detail

As of: 08/31/2019 Activity Period: 08/01/2019 - 08/31/2019

LOSS DETAILS													TOTALS			
	Status	Loss Age	Dates Loss	Dates Knowledge	Act	Type	Job Code	Juris	Life Med	Days L	Days R	Activity Paid	Paid	Reserves	Incurred
Redacted (Continued)															
Redacted - Department 2															
Claim #: 15491130	O	56	01/27/2016	01/27/2016	N	Inde	1100B	CA	N	79	0	151.73	35,596.38	32,470.80	68,067.18
Claimant: [redacted] **Tax ID:** xxx-xx-[redacted]3															
Loss Desc: 57 year old female Accounting Clerk II tripped on area rug in front of lobby and fell. EE broke her fall, injuring right wrist, right knee, low back and hit head on elevator., Multiple injuries to Multiple body parts from CONTUSIONS by Walking at 09:00															
									Indemnity			0.00	6,397.42	13,419.76	19,817.18
									Medical			141.78	24,653.51	17,296.49	41,950.00
									Other			9.95	4,545.45	1,754.55	6,300.00
									Total			151.73	35,596.38	32,470.80	68,067.18
										79	0				

Ending Open:	1
Ending Closed:	0
Total:	1

Indemnity	0.00	6,397.42	13,419.76	19,817.18
Medical	141.78	24,653.51	17,296.49	41,950.00
Other	9.95	4,545.45	1,754.55	6,300.00
Total	151.73	35,596.38	32,470.80	68,067.18

Sample Frequency Reports

Frequency Analysis - Loss Type

Loss Dates: 01/01/1900 - 07/31/2019

As Of 07/31/2019

All Insureds — **Totals**

Loss Type	Open	Total	Days Rest.	Days Lost	Avg. Days	Paid	Incurred	Avg. Paid	Max. Paid	Reserves	% of Insured's Total Claims	% of Insured's Total Paid	% of Insured's Total Incurred
Medical Only	11	997	0	7	0	362,074.50	377,607.78	363.16	3,046.78	15,533.28	47.7	2.1	1.6
Indemnity	77	859	104	16,437	19	9,971,191.74	11,186,143.68	11,607.91	335,661.22	1,214,951.94	41.1	56.8	47.6
Temp. Total or Part. Dis. (0.00%	9	116	21	3,545	31	1,246,457.01	1,622,975.61	10,745.32	207,918.07	376,518.60	5.5	7.1	6.9
FM Minor permanent partial 24.9	23	42	0	2,258	54	1,788,533.92	2,436,220.01	42,584.14	253,465.82	647,686.09	2.0	10.2	10.4
NEVER USE<Not Assigned>	21	21	0	0	0	0.00	0.00	0.00	0.00	0.00	1.0	0.0	0.0
Closed Death Claim, C&R AOEC	18	18	0	0	0	0.00	0.00	0.00	0.00	0.00	0.9	0.0	0.0
Minor permanent partial 24.999%	5	16	84	3,112	200	656,618.20	770,790.73	41,038.64	150,334.91	114,172.53	0.8	3.7	3.3
FM Major permanent partial 25%	8	12	0	2,895	241	1,861,710.68	5,083,640.00	155,142.56	511,163.39	3,221,929.32	0.6	10.6	21.6
Major permanent partial 25% or >	1	8	3	2,268	284	912,115.08	934,862.95	114,014.39	253,470.11	22,747.87	0.4	5.2	4.0
Death	1	1	0	56	56	279,810.20	588,366.11	279,810.20	279,810.20	308,555.91	0.0	1.6	2.5
First Aid (CA)	0	1	0	0	0	0.00	0.00	0.00	0.00	0.00	0.0	0.0	0.0
Information Only	0	1	0	0	0	485,685.54	485,685.54	485,685.54	485,685.54	0.00	0.0	2.8	2.1

ACCLAMATION INSURANCE MANAGEMENT SERVICES

Frequency Analysis - Loss Type

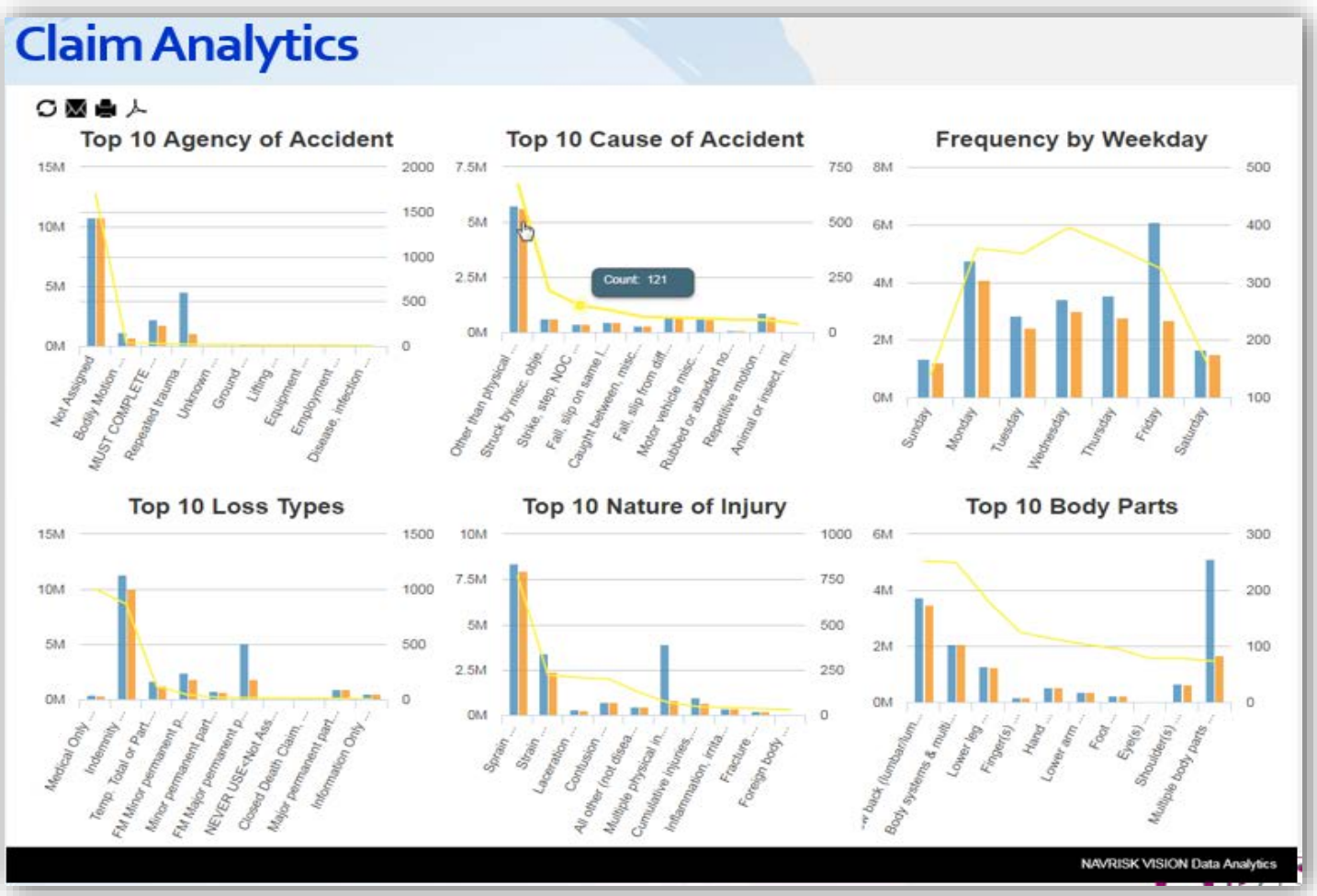
Loss Dates: 01/01/1900 - 07/31/2019

As Of 07/31/2019

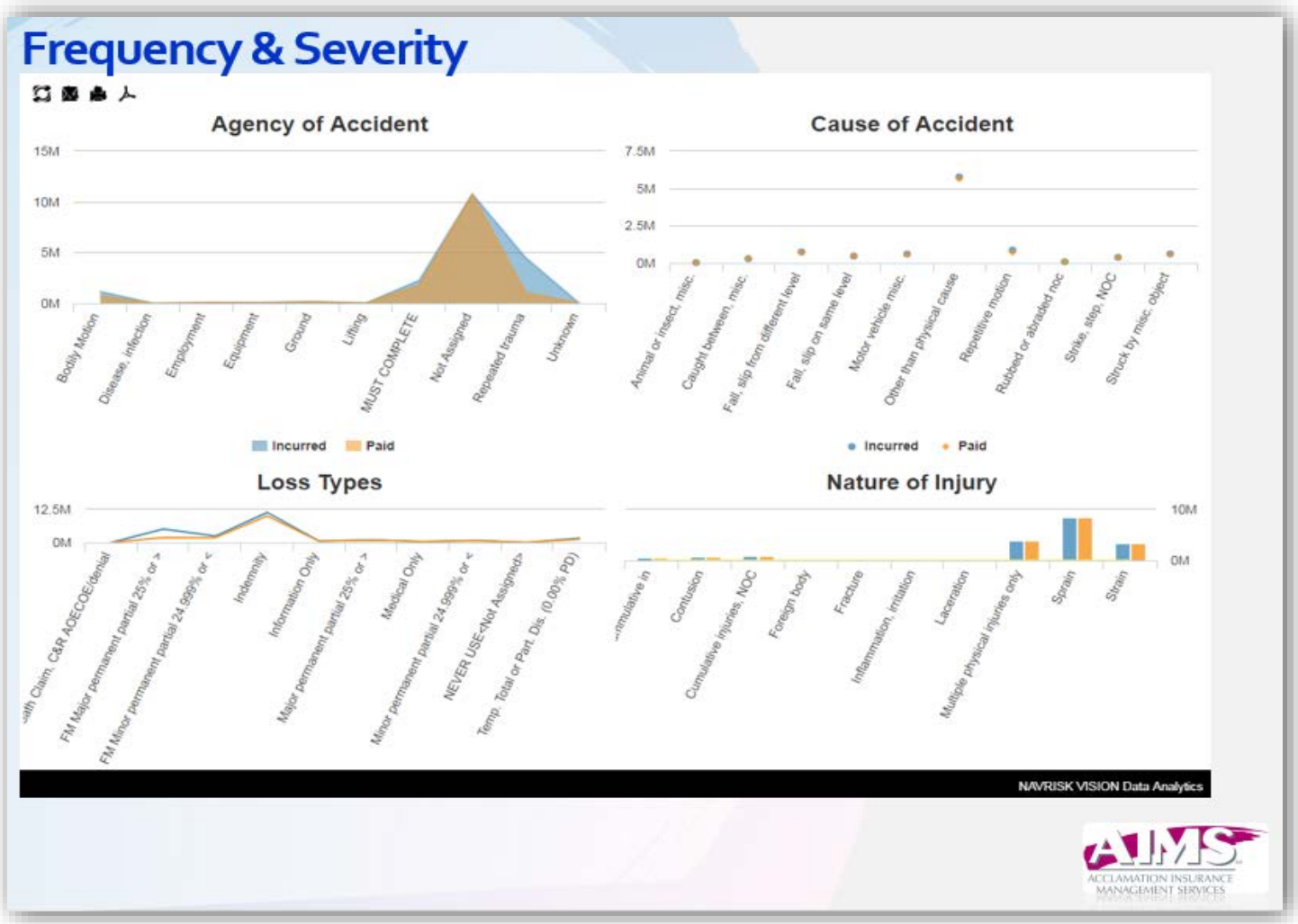
Totals

Loss Type	Open	Total	Days Rest.	Days Lost	Avg. Days	Paid	Incurred	Avg. Paid	Max. Paid	Reserves	% of Insured's Total Claims	% of Insured's Total Paid	% of Insured's Total Incurred
GRAND TOTALS	174	2,092	212	30,578	15	17,564,196.87	23,486,292.41	8,395.89	511,163.39	5,922,095.54	100.0	100.0	100.0

Sample Dashboard Screenshots



Sample Dashboard Screenshots


Frequency & Severity
Agency of Accident
15M
10M
5M
0M
Bodily Motion
Disease, infection
Employment
Equipment
Ground
Lifting
MUST COMPLETE
Not Assigned
Repeated trauma
Unknown
Incurred
Paid
Cause of Accident
7.5M
5M
2.5M
0M
Animal or insect, misc.
Caught between, misc.
Fall, slip from different level
Fall, slip on same level
Motor vehicle misc.
Other than physical cause
Repetitive motion
Rubbed or abraded noc
Strike, step, NOC
Struck by misc object
Incurred
Paid
Loss Types
12.5M
0M
FM Major permanent partial 25% or >
FM Minor permanent partial 24.999% or <
Indemnity
Information Only
Major permanent partial 25% or >
Medical Only
Minor permanent partial 24.999% or <
NEVER USE<Not Assigned>
Temp. Total or Part. Dis. (0.00% PD)
Nature of Injury
10M
0M
Contusion
Cumulative injuries, NOC
Foreign body
Fracture
Inflammation, irritation
Laceration
Multiple physical injuries only
Sprain
Strain
NAVRISK VISION Data Analytics

Sample Claim Status Report

ACCLAMATION INSURANCE MANAGEMENT SERVICES

CLAIM STATUS REPORT

Claim Overview

Loss Date: 06/13/2005
Dept.: 0900/1000 Public Safety
Hire Date: 06/04/2004
Age at Injury: 25
Birthdate: 10/18/1979

Claimant: John Doe1005
Claim Number: 05138028
Job Title: Police Dispatch
LDW: 06/13/2005
Age: 35
RTW: TBD
Medicare Eligible: No

Claim Coding

Examiner: Dee Poser

Loss Type: Indemnity

Accident Description: Nature of accident: REPETITIVE MOTION Nature of injury: CARPAL TUNNEL SYNDROME Body part: WRIST, RIGHT Incident type: REPETITIVE MOTION/TYPING

Nurse Case Manager: Flora Nightingale

TTD Rate:$0.00

Legal

Defense Counsel:
Applicant Attorney:
Case Resolution:

Financial Detail

Reserve Category	Incurred	Paid	Outstanding
Indemnity	$ 5,965.43	$ 5,438.96	$ 526.47
Temporary Disability	$1,345.43	$ 5,438.96	$ 526.47
Permanent Disability	$4,620.00	$ 4,620.00	$ 0.00
Medical	$ 9,687.77	$ 912.84	$ 8,774.93
Legal	$ 0.00	$ 0.00	$ 0.00
Other	$ 1,470.91	$ 390.57	$ 1,080.34
Total			

Last TD Paid:

Last PD Paid:

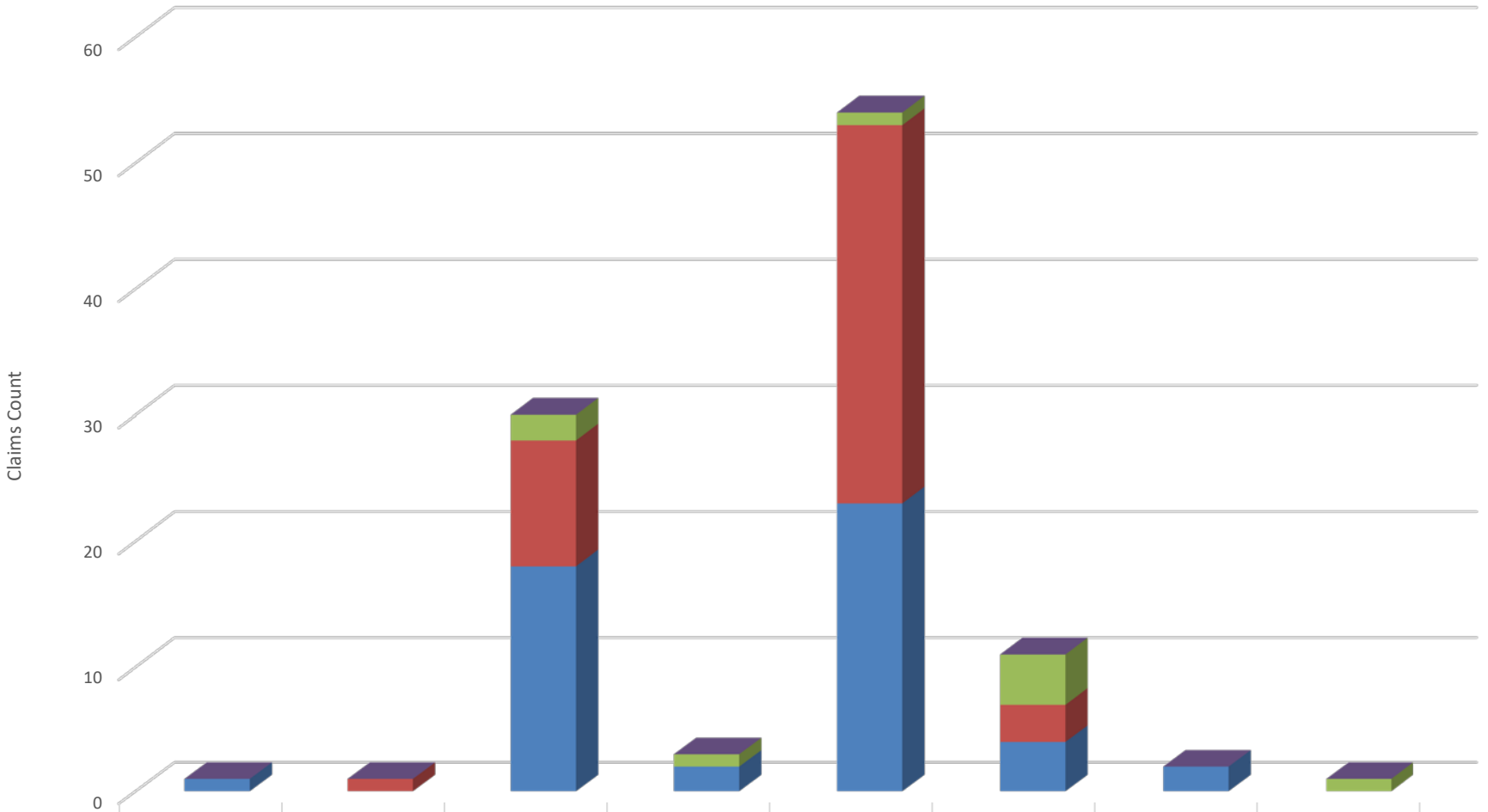
Plan of Action/Status

Disability status:
Current Issues:
Medical Status:
Plan of Action:

Dated: November 24, 2019

Key Metrics by Location

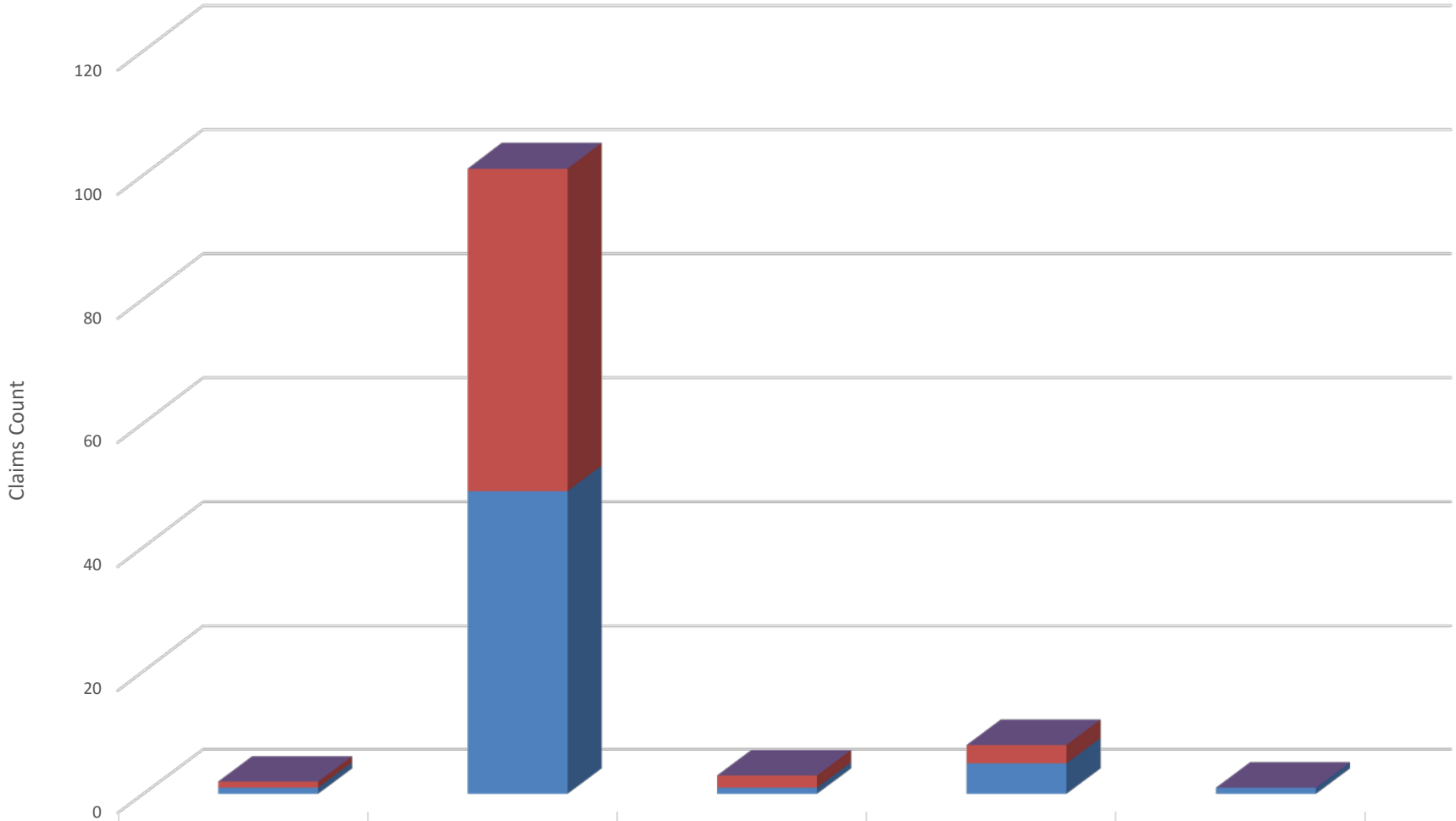
[redacted] Claims Count by Department
Fiscal Year 2016/2017



	City Clerk	City Corp	Environmental Resources	Facilities Maintenance	Fire Dept	Fleet Services	Human Resources	Human Services
Info Only	0	0	0	0	0	0	0	0
First Aid	0	0	2	1	1	4	0	1
Med Only	0	1	10	0	30	3	0	0
Indemnity	1	0	18	2	23	4	2	0

ACCLAMATION INSURANCE MANAGEMENT SERVICES

[redacted] Claims Count by Department
Fiscal Year 2016/2017



	Leisure And Recreation	Police Dept	Public Works	Wastewater Department	Water Department
Info Only	0	0	0	0	0
First Aid	0	0	0	0	0
Med Only	1	52	2	3	0
Indemnity	1	49	1	5	1

Claims Administration Fees and Claim Payments

ACCLAMATION INSURANCE MANAGEMENT SERVICES

Financial Activity Ledger

Date Report Run: 6/17/20

Time Report Run: 3:09:38PM

Activity Period:

Check No	Effective	Trans Type	Check Date	Type	Payee Name	Claim No	Claimant Name	Amount
Bank Account: Emerald City								
AA-ACME-WC Demo / 0900/1000 Public Safety								
16772	06/17/2011	Check	06/17/2011	I8	Redacted	2030026	Doe890 , John	1,456.00
16773	06/17/2011	Voucher	06/17/2011	I40	Redacted	ME110079	Doe940 , John	1,680.00
16774	06/17/2011	Voucher	06/17/2011	I94	Redacted	ME110079	Doe940 , John	840.00
16777	06/17/2011	Voucher	06/17/2011	I40	Redacted	ME110064	Doe344 , John	1,552.03
16778	06/17/2011	Voucher	06/17/2011	I94	Redacted	ME110064	Doe344 , John	776.10
16779	06/17/2011	Voucher	06/17/2011	I40	Redacted	ME110087	Doe1028 , John	697.26
16781	06/17/2011	Voucher	06/17/2011	I40	Redacted	08220491	Doe945 , John	1,946.48
16782	06/17/2011	Voucher	06/17/2011	I94	Redacted	08220491	Doe945 , John	973.22
16783	06/17/2011	Voucher	06/17/2011	I40	Redacted	06174393	Doe159 , John	1,973.38
0	06/23/2011	Refund	06/23/2011	M47	Redacted	8600505	Doe165 , John	-96.41

Totals for AA-ACME-WC Demo / 0900/1000 Public Safety

	Count	Total
Payments:	9	11,894.47
Reversals:	0	0.00
Reinstatements:	0	0.00
Refunds:	1	-96.41
Reversed Refunds:	0	0.00
Net Amount		11,798.06

** = Break in check number sequence or duplicate check number(s)*

ACCLAMATION INSURANCE MANAGEMENT SERVICES

Financial Activity Ledger

Activity Period: 6/17/11 - 6/23/11

Date Report Run: 6/17/20

Time Report Run: 3:09:38PM

Check No	Effective	Trans Type	Check Date	Type	Payee Name	Claim No	Claimant Name	Amount
AA-ACME-WC Demo / 1100 Public Works Operations								
16775	06/17/2011	Voucher	06/17/2011	I40	Redacted	ME100056	Doe1828 , John	1,147.39
16776	06/17/2011	Voucher	06/17/2011	I40	Redacted	ME100005	Doe1835 , John	1,205.44
16780	06/17/2011	Voucher	06/17/2011	I40	Redacted	ME110075	Doe1559 , John	1,321.23
16784	06/17/2011	Voucher	06/17/2011	I40	Redacted	ME090023	Doe1359 , John	1,198.39

Totals for AA-ACME-WC Demo / 1100 Public Works Operations

	Count	Total
Payments:	4	4.872.45
Reversals:	0	0.00
Reinstatements:	0	0.00
Refunds:	0	0.00
Reversed Refunds:	0	0.00
Net Amount		4.872.45

** = Break in check number sequence or duplicate check number(s)*

Sample Reconciliation Report

ACCLAMATION INSURANCE MANAGEMENT SERVICES

Sample Client Reconciliation Check Register

November 1 - 30, 2014

Check No	Date	Amount	Type	Pay Type	Payee	Claim No	Claimant
79139 √	11/03/2014	720.38	Payment	I1	Dolores Machtolff	00200308	Machtolff, Dolores
79140 √	11/03/2014	352.50	Payment	M25	Allied Managed Care, Inc.	01201848	Poplawski, Evelyn
79141 √	11/03/2014	648.00	Payment	M3	ECONOMY TRANSPORT LLC	01201848	Poplawski, Evelyn
79142 √	11/03/2014	1,200.00	Payment	M44	myMatrixx	00200341	Alcaraz, Raleigh
79143 √	11/04/2014	340.00	Payment	I2	Arnulfo Velasco	01200654	Velasco, Arnulfo
79144 √	11/05/2014	833.00	Payment	I14	Kathryn Adame	01201464	Adame, Kathryn
79145 √	11/05/2014	833.00	Payment	I14	Kathryn Adame	01201464	Adame, Kathryn
79146 √	11/05/2014	396.00	Payment	L1	LAW OFFICES OF ROBERT WHEATLEY	01201049	Molina, Francisco
79147 √	11/05/2014	412.50	Payment	L1	LAW OFFICES OF ROBERT WHEATLEY	01201049	Molina, Francisco
79148 √	11/05/2014	506.80	Payment	L1	LAW OFFICES OF VILEISIS, BRUSH	A150000282	Robinson, Ladonna
79149 √	11/05/2014	564.39	Payment	M37	One Call Care Transport & Translate	02000336	Hall, Stephen
79150 √	11/06/2014	833.00	Payment	I14	Kathryn Adame	01201464	Adame, Kathryn
79151 √	11/06/2014	799.24	Payment	I2	Evelyn Poplawski	01201848	Poplawski, Evelyn
79152 √	11/06/2014	355.20	Payment	M33	Stephen W Hall	02000336	Hall, Stephen
79153 √	11/06/2014	589.86	Payment	M33	Stephen W Hall	02000336	Hall, Stephen
79154 √	11/06/2014	140.00	Payment	M33	Stephen W Hall	02000336	Hall, Stephen
79155 √	11/06/2014	14.56	Payment	M33	Stephen W Hall	02000336	Hall, Stephen
79156 √	11/06/2014	8,211.92	Payment	L1	Floyd, Skeren, & Kelly, LLP	00200341	Alcaraz, Raleigh
79157 √	11/06/2014	1,127.45	Payment	L1	LAW OFFICES OF BRADFORD & BARTHEL, LI	04000276	Perez, Naborina
79158 √	11/06/2014	80.30	Payment	L1	LAW OFFICES OF BRADFORD & BARTHEL, LI	03000126	Maya, Nina
79159 √	11/06/2014	155.60	Payment	L1	LAW OFFICES OF BRADFORD & BARTHEL, LI	01200647	Rodriguez, Francisco
79160 √	11/06/2014	105.00	Payment	L1	LAW OFFICES OF BRADFORD & BARTHEL, LI	01201848	Poplawski, Evelyn
79161 √	11/06/2014	2,232.78	Payment	L1	LAW OFFICES OF BRADFORD & BARTHEL, LI	02000362	Romo, Maria
79162 √	11/06/2014	752.60	Payment	L1	LAW OFFICES OF BRADFORD & BARTHEL, LI	01200810	Ryan, Claudia
79163 √	11/07/2014	.00	Payment	M47	BAY AREA PAIN & WELLNESS CENTE	01201464	Adame, Kathryn
79164 √	11/07/2014	54.99	Payment	M44	Coastal Express Pharmacy	03000126	Maya, Nina
79165 √	11/07/2014	264.36	Payment	M44	Coastal Express Pharmacy	00200341	Alcaraz, Raleigh
79166 √	11/07/2014	159.02	Payment	M46	DAVID TORREZ PHD MFT A COUNSEL	01200647	Rodriguez, Francisco
79167 √	11/07/2014	.00	Payment	M54	Diogenes Anesthesia Medical Gr	00200341	Alcaraz, Raleigh
79168 √	11/07/2014	.00	Payment	M54	Diogenes Anesthesia Medical Gr	00200341	Alcaraz, Raleigh
79169 √	11/07/2014	353.29	Payment	M44	Express Scripts Inc	01201464	Adame, Kathryn
79170 √	11/07/2014	137.05	Payment	M47	Isaac Schmidt, MD	00200341	Alcaraz, Raleigh
79171 √	11/07/2014	125.14	Payment	M47	Joshua Prager MD MS	01201848	Poplawski, Evelyn
79172 √	11/07/2014	719.56	Payment	M47	Joshua Prager MD MS	01201848	Poplawski, Evelyn
79173 √	11/07/2014	120.00	Payment	M3	Maid Pro	00200217	Tapia, Maria
79174 √	11/07/2014	120.86	Payment	M44	MICHAEL`S PHARMACY	01200989	Velasco, Arnulfo
79175 √	11/07/2014	74.60	Payment	M47	P.R.I.M.E. PAIN MEDICINE INSTI	02000114	Lyle, James
79176 √	11/07/2014	474.56	Payment	I2	Maria Tapia	00200217	Tapia, Maria
79177	11/10/2014	616.96	Payment	I2	Nina Maya	03000126	Maya, Nina
79178 √	11/10/2014	305.54	Payment	I14	Raleigh Alcaraz	00200341	Alcaraz, Raleigh
79179 √	11/10/2014	431.14	Payment	I2	Richard Menendez	02000102	Menendez, Richard
79180 √	11/11/2014	124.78	Payment	M47	BAY AREA PAIN & WELLNESS CENTE	01201464	Adame, Kathryn
79181 √	11/11/2014	124.78	Payment	M47	BAY AREA PAIN & WELLNESS CENTE	01201464	Adame, Kathryn
79182 √	11/11/2014	.00	Payment	M28	MSC GROUP INC	00200217	Tapia, Maria
79183 √	11/11/2014	465.00	Payment	M28	MSC GROUP INC	00200217	Tapia, Maria
79184 √	11/11/2014	.00	Payment	M28	MSC GROUP INC	00200217	Tapia, Maria
79185 √	11/11/2014	.00	Payment	M28	MSC Group, Inc.	00200217	Tapia, Maria
79186 √	11/11/2014	.00	Payment	M28	MSC Group, Inc.	00200217	Tapia, Maria
79187 √	11/12/2014	180.00	Payment	O6	DocCentral	02000102	Menendez, Richard
79188 √	11/12/2014	182.30	Payment	O6	DocCentral	02000102	Menendez, Richard
79189	11/12/2014	128.00	Payment	L1	Aitman, Lunche & Blitstein	A250002778	Pillot, Mary
79190 √	11/12/2014	168.35	Payment	L6	DocCentral	02000102	Menendez, Richard
79191	11/12/2014	240.00	Payment	L1	LAW OFFICES OF MARGARET R. STE	01201377	Sharp, Marsanna
79192 √	11/12/2014	115.50	Payment	L1	LAW OFFICES OF ROBERT WHEATLEY	02000543	Macias, Rafael
79193 √	11/12/2014	132.00	Payment	L1	LAW OFFICES OF ROBERT WHEATLEY	01201049	Molina, Francisco
79194 √	11/12/2014	1,480.03	Payment	L1	LAW OFFICES OF ROBERT WHEATLEY	02000543	Macias, Rafael
79195 √	11/12/2014	360.00	Payment	L1	LOUIE & STETTLER, A LAW CORPOR	00200217	Tapia, Maria
79196	11/12/2014	300.25	Payment	L1	LOUIE & STETTLER, A LAW CORPOR	00200217	Tapia, Maria

Check No	Date	Amount	Type	Pay Type	Payee	Claim No	Claimant
79197 √	11/12/2014	540.50	Payment	L1	LOUIE & STETTLER, A LAW CORPOR	00200217	Tapia, Maria
79198 √	11/14/2014	833.00	Payment	I14	Kathryn Adame	01201464	Adame, Kathryn
79199 √	11/14/2014	352.50	Payment	O34	Allied Managed Care	00200217	Tapia, Maria
79200 √	11/14/2014	352.50	Payment	O34	Allied Managed Care, Inc.	02000102	Menendez, Richard
79201 √	11/14/2014	549.13	Payment	M25	CASE MANAGEMENT SOLUTIONS	02000336	Hall, Stephen
79202 √	11/14/2014	728.00	Payment	M37	CENTURY PACIFIC MEDICAL INC	03000126	Maya, Nina
79203 √	11/14/2014	728.00	Payment	M37	CENTURY PACIFIC MEDICAL INC	03000126	Maya, Nina
79204 √	11/14/2014	728.00	Payment	M37	CENTURY PACIFIC MEDICAL INC	03000126	Maya, Nina
79205 √	11/14/2014	728.00	Payment	M37	CENTURY PACIFIC MEDICAL INC	03000126	Maya, Nina
79206 √	11/14/2014	194.95	Payment	M44	Coastal Express Pharmacy	01201049	Molina, Francisco
79207 √	11/14/2014	270.00	Payment	M30	COSSIOS INTERNATIONAL LINGUIST	00200217	Tapia, Maria
79208 √	11/14/2014	.00	Payment	M47	DARREL H. BURNSTEIN, M.D. A ME	02000102	Menendez, Richard
79209 √	11/14/2014	137.05	Payment	M47	DAVID FUCHS M.D., INC.	02000102	Menendez, Richard
79210 √	11/14/2014	137.05	Payment	M47	DAVID FUCHS M.D., INC.	02000102	Menendez, Richard
79211 √	11/14/2014	137.05	Payment	M47	DAVID FUCHS M.D., INC.	02000102	Menendez, Richard
79212 √	11/14/2014	137.05	Payment	M47	DAVID FUCHS M.D., INC.	02000102	Menendez, Richard
79213 √	11/14/2014	411.15	Payment	M47	DAVID FUCHS M.D., INC.	02000102	Menendez, Richard
79214 √	11/14/2014	30.79	Payment	M44	Express Scripts Inc	01201464	Adame, Kathryn
79215 √	11/14/2014	188.99	Payment	M44	Express Scripts Inc	01201464	Adame, Kathryn
79216 √	11/14/2014	388.96	Payment	M47	Grabow Medical Group Inc.	00200217	Tapia, Maria
79217 √	11/14/2014	130.19	Payment	M47	HAIDER SPINE CENTER MEDICAL GR	01201049	Molina, Francisco
79218 √	11/14/2014	197.12	Payment	M47	Hamlin Psyche Center	02000102	Menendez, Richard
79219 √	11/14/2014	125.14	Payment	M47	Joshua Prager MD MS	02000102	Menendez, Richard
79220 √	11/14/2014	120.00	Payment	M8	Maid Pro	00200217	Tapia, Maria
79221 √	11/14/2014	120.00	Payment	M3	Maid Pro	00200217	Tapia, Maria
79222 √	11/14/2014	120.00	Payment	M3	Maid Pro	00200217	Tapia, Maria
79223 √	11/14/2014	120.00	Payment	M3	Maid Pro	00200217	Tapia, Maria
79224 √	11/14/2014	120.86	Payment	M44	MICHAEL`S PHARMACY	01200989	Velasco, Arnulfo
79225 √	11/14/2014	.00	Payment	M46	MIRFAK ASSOCIATES, INC.	02000114	Lyle, James
79226 √	11/14/2014	1,864.90	Payment	M44	myMatrixx	02000336	Hall, Stephen
79227 √	11/14/2014	101.13	Payment	M44	myMatrixx	01201117	Diaz, Rosa
79228 √	11/14/2014	112.21	Payment	M44	myMatrixx	01201117	Diaz, Rosa
79229 √	11/14/2014	74.60	Payment	M47	P.R.I.M.E. PAIN MEDICINE INSTI	02000114	Lyle, James
79230 √	11/14/2014	187.39	Payment	M28	Priority Care Solutions LLC	00200217	Tapia, Maria
79231 √	11/14/2014	.00	Payment	M18	Priority Care Solutions LLC	00200217	Tapia, Maria
79232 √	11/14/2014	40.00	Payment	M28	RS MEDICAL	00200217	Tapia, Maria
79233 √	11/14/2014	40.00	Payment	M28	RS MEDICAL	00200217	Tapia, Maria
79234 √	11/14/2014	152.21	Payment	M47	SOUTHLAND SPINE AND REHABILITA	00200090	Gonzalez, Ana Rosa
79235 √	11/14/2014	289.22	Payment	M47	SOUTHLAND SPINE AND REHABILITA	00200090	Gonzalez, Ana Rosa
79236 √	11/14/2014	203.79	Payment	M47	SOUTHLAND SPINE AND REHABILITA	00200090	Gonzalez, Ana Rosa
79237 √	11/14/2014	45.16	Payment	M44	STONERIVER PHARMACY SOLUTIONS	01201848	Poplawski, Evelyn
79238 √	11/14/2014	1,353.11	Payment	M44	STONERIVER PHARMACY SOLUTIONS	01201848	Poplawski, Evelyn
79239 √	11/14/2014	202.44	Payment	M44	Stoneriver Pharmacy Solutions	00200217	Tapia, Maria
79240 √	11/14/2014	270.46	Payment	M44	TMESYS, INC	00200217	Tapia, Maria
79241 √	11/14/2014	44.15	Payment	M44	TMESYS, INC	00200217	Tapia, Maria
79242 √	11/17/2014	720.38	Payment	I1	Dolores Machtolff	00200308	Machtolff, Dolores
79243 √	11/18/2014	340.00	Payment	I2	Arnulfo Velasco	01200654	Velasco, Arnulfo
79244 √	11/20/2014	799.24	Payment	I2	Evelyn Poplawski	01201848	Poplawski, Evelyn
79245 √	11/21/2014	474.56	Payment	I2	Maria Tapia	00200217	Tapia, Maria
79246	11/21/2014	180.00	Payment	O6	DocCentral	02000102	Menendez, Richard
79247	11/21/2014	223.40	Payment	M36	FRANCISCO MOLINA	01201049	Molina, Francisco
79248	11/21/2014	120.00	Payment	M8	Maid Pro	00200217	Tapia, Maria
79249	11/21/2014	120.00	Payment	M8	Maid Pro	00200217	Tapia, Maria
79250 √	11/21/2014	970.07	Payment	L1	SOUTHLAND SPINE AND REHABILITA	00200090	Gonzalez, Ana Rosa
79251	11/24/2014	304.54	Payment	I14	Raleigh Alcaraz	00200341	Alcaraz, Raleigh
79252 √	11/24/2014	431.14	Payment	I2	Richard Menendez	02000102	Menendez, Richard
79253	11/25/2014	616.96	Payment	I2	Nina Maya	03000126	Maya, Nina
79254	11/26/2014	833.00	Payment	I14	Kathryn Adame	01201464	Adame, Kathryn
78616 √	11/03/2014	-35.99	Reversal	M33	Francisco J. Rodriguez	01200647	Rodriguez, Francisco
79068 √	11/17/2014	-833.00	Reversal	I14	Kathryn Adame	01201464	Adame, Kathryn

EXHIBIT 14 –
Certificate of Insurance

Client#: 6105 ACCLINSU

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 12/17/2021

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer any rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Edgewood Partners Ins Center
One California Street, Suite 400
Lic#0B29370 (415)356-3900
San Francisco, CA 94111

CONTACT NAME: Laurie Martin
PHONE (A/C, No, Ext): - **FAX (A/C, No):**
E-MAIL ADDRESS: laurie.martin@epicbrokers.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : National Fire Ins of Hartford	20478
INSURER B : The Continental Insurance Company	35289
INSURER C : State Compensation Ins. Fund	35076
INSURER D : Landmark American Ins. Co.	33138
INSURER E : Valley Forge Insurance Co	20508
INSURER F : Houston Casualty Co.	42374

INSURED
Acclamation Insurance Management
10445 Old Placerville Road
Sacramento, CA 95827

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE / X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY / PRO-JECT / X LOC OTHER:			6056760864	01/01/2022	01/01/2023	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$1,000,000 $1,000,000 $15,000 $1,000,000 $2,000,000 $2,000,000
E	AUTOMOBILE LIABILITY X ANY AUTO OWNED AUTOS ONLY / SCHEDULED AUTOS X HIRED AUTOS ONLY / X NON-OWNED AUTOS ONLY			6056760850	01/01/2022	01/01/2023	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$1,000,000 $ $ $
B	X UMBRELLA LIAB / X OCCUR EXCESS LIAB / CLAIMS-MADE DED / X RETENTION $10000			6056760878	01/01/2022	01/01/2023	EACH OCCURRENCE AGGREGATE	$10,000,000 $10,000,000
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N: N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		908337922	01/01/2022	01/01/2023	X PER STATUTE / OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $1,000,000 $1,000,000 $1,000,000
D	Professional Liab			LHR843573	07/11/2021	07/11/2022	$5,000,000 agg E&O	
F	Privacy Liability			H21NGP20937501	07/11/2021	07/11/2022	$5,000,000 agg Cyber $25,000 SIR E&O & Cyber	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Claims administration services including Nurse Case Management and Bill Review.

Named insured includes: Acclamation Insurance Management Services, Inc.; Allied Managed Care, Inc.; LJR Holdings, Inc.; LJR Properties, LLC; CarivaCare, Inc.

(See Attached Descriptions)

CERTIFICATE HOLDER
City of Richmond ATTN: Risk Manager
450 Civic Center Plaza 3rd Floor
Richmond, CA 94804-0000

CANCELLATION
SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
Earl Hoole

DESCRIPTIONS (Continued from Page 1)

Thirty day notice of cancellation will be provided to the certificate holder but 10 days for non-payment of premium.

EMPLOYEE DISHONESTY / CRIME COVERAGE: Travelers Property & Casualty Insurance Company. #107196186 EFF: 1/1/22 EXP: 1/1/23 DISHONESTY LIMIT: $2,000,000 $20,000 DEDUCTIBLE

Claims administration services and cost containment contract.

The City of Richmond, its officers, officials, employees, agents and volunteers are listed as additional insureds for all liability arising out of the operations by or on behalf of the named insured including bodily injury, deaths and property damage or destruction arising in any respect directly or indirectly in the performance of this contract, where required by written contract. General Liability insurance is primary and non-contributory with certificate holder's insurance. Workers Compensation Waiver of Subrogation endorsement is attached to the Workers Compensation policy.

CNA

CNA PARAMOUNT

Financial Services - General Liability Extension Endorsement

It is understood and agreed that this endorsement amends the **COMMERCIAL GENERAL LIABILITY COVERAGE PART** as follows. If any other endorsement attached to this policy amends any provision also amended by this endorsement, then that other endorsement controls with respect to such provision, and the changes made by this endorsement with respect to such provision do not apply.

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CNA

CNA PARAMOUNT

Financial Services - General Liability Extension Endorsement

1. ADDITIONAL INSUREDS

a. **WHO IS AN INSURED** is amended to include as an **Insured** any person or organization described in paragraphs **A.** through **K.** below whom a **Named Insured** is required to add as an additional insured on this **Coverage Part** under a written contract or written agreement, provided such contract or agreement:

(1) is currently in effect or becomes effective during the term of this **Coverage Part**; and

(2) was executed prior to:

(a) the **bodily injury** or **property damage**; or

(b) the offense that caused the **personal and advertising injury**,

for which such additional insured seeks coverage.

b. However, subject always to the terms and conditions of this policy, including the limits of insurance, the Insurer will not provide such additional insured with:

(1) a higher limit of insurance than required by such contract or agreement; or

(2) coverage broader than required by such contract or agreement, and in no event broader than that described by the applicable paragraph **A.** through **K.** below.

Any coverage granted by this endorsement shall apply only to the extent permissible by law.

A. Controlling Interest

Any person or organization with a controlling interest in a **Named Insured**, but only with respect to such person or organization's liability for **bodily injury**, **property damage** or **personal and advertising injury** arising out of:

1. such person or organization's financial control of a **Named Insured**; or

2. premises such person or organization owns, maintains or controls while a **Named Insured** leases or occupies such premises;

provided that the coverage granted by this paragraph does not apply to structural alterations, new construction or demolition operations performed by, on behalf of, or for such additional insured.

B. Co-owner of Insured Premises

A co-owner of a premises co-owned by a **Named Insured** and covered under this insurance but only with respect to such co-owner's liability for **bodily injury**, **property damage** or **personal and advertising injury** as co-owner of such premises.

C. Grantor of Franchise

Any person or organization that has granted a franchise to a **Named Insured**, but only with respect to such person or organization's liability for **bodily injury**, **property damage** or **personal and advertising injury** as grantor of a franchise to the **Named Insured**.

D. Lessor of Equipment

Any person or organization from whom a **Named Insured** leases equipment, but only with respect to liability for **bodily injury**, **property damage** or **personal and advertising injury** caused, in whole or in part, by the **Named Insured's** maintenance, operation or use of such equipment, provided that the **occurrence** giving rise to such **bodily injury**, **property damage** or the offense giving rise to such **personal and advertising injury** takes place prior to the termination of such lease.

EXHIBIT 15 –
Proposer Qualifications

Exhibit 15 – PROPOSER QUALIFICATIONS

Proposer Qualifications

Claims Administration

A. Firm's s: Describe the firm and provide a statement of qualifications for performing the requested scope of services as outlined in Scope of Services-Claims Administration Services. Identify the firm's primary service office for the City's account. Provide a company-wide organizational chart with reference to the proposed service office and proposed service team.

Please see the main body of our proposal Firm Description and attached Exhibit of AIMS Organization Charts.

B. Service Team Qualifications: Provide an organizational chart outlining your proposed service team including names, titles, and length of service in your organization. For each proposed team member, provide a summary of qualifications including claims handling experience, indemnity case load, experience working with public entity self-insured entities, education, and any professional designations and awards. Include full resumes for each member of your proposed service team. If you have not designed staff to service the City's account, provide the selection qualifications for any staff necessary to service the City's account.

See attached Exhibit of AIMS Organization Charts and Team Resumes.

C. Claims Administrative Services: Describe your firm's claims administration policies, procedures, and best practices that ensure superior service to City employees while maintaining economic and administrative control over claims costs. Discuss your claims reserving philosophy and indicate the maximum number of indemnity files handled by your proposed claims examiners.

Policies and Practices: AIMS has customized all procedures to meet the Scope of Work requirements of the City. AIMS administers our California Clients' self-insurance plans in full compliance with all laws, rules and regulations governing the administration of self-insurance pursuant to Sections 3700 et seq. of the Labor Code and the California Administrative Procedure Act as set forth in Government Code, Title 2, Div. 3. Part I, Chapter 4 and 5 in effect at the time of submission of our response to this RFP as amended during the period that any contract with the Client is in effect and any other laws, rules, and regulations that govern the handling of California Workers' Compensation claims.

A true partnership between the Client and the administrator is imperative to the successful management of a workers' compensation program. This relationship takes a high level of communication, trust and a lot of work. Our hands-on team approach is what has led to the development of many strong partnerships over the years. This has involved partnering with the City to assess specific needs and then developing a customized claims

management program designed to combat claim exposures and costs for the City. The key elements of the program are:

- Define - Learn and evaluate needs of the customer
- Perform - Deliver and be accountable to expectations
- Measure - Analyze effectiveness
- Report – Present hard data
- Recommend – Suggest proactive strategies to improve results

Superior Client Service to City employees: As a Client-driven organization, AIMS delivers measurable financial results to our Clients through our intelligent use of innovative technology and a flexible, yet disciplined, approach to service delivery with fiscal accountability. We nurture long-term relationships by providing our Clients with technically competent, experienced, and dedicated staff, acting with integrity in all that we do.

Our commitment to great Client service is the same at every level of our organization - from our front line employees to our senior managers. Clients evaluate our performance based on the responsiveness of our employees. When we consistently meet our commitments with enthusiasm and timeliness, the entire organization benefits, and our Clients becomes our advocates.

It is every employee's responsibility to:

- Listen for understanding
- Show empathy
- Find solutions
- Anticipate needs
- Follow through on commitments

"Serving Clients is our purpose. Client service is our passion."

- **Client Service Initiative:** Seven years ago we launched a Client Service initiative directed at improving and providing a higher level of Client service for our current and future Clients. In the initial phase of the program we focused specifically on training and investing in our managers and staff bringing them on board with our goals and initiatives. Our training efforts have continued regularly since that time with an ultimate objective: to better understand, from our Client's perspective, how we at AIMS interact with you on a day to day basis.
- **Client Relations Director:** AIMS has implemented the second phase of our Client service program by establishing a Client Relations role within AIMS. We felt it was vitally important to have a position solely focused on maintaining and improving client satisfaction. Therefore, we have established and assigned the position of Director of Client Relations. This individual is in charge of developing a better understanding of how we work together and how we at AIMS can provide even better service. Our Director of Client Relations contacts Client staff that interacts with us on day to day basis and asks questions concerning Client experiences with AIMS, both good and bad. This information is then provided to AIMS senior management for review and issue resolution responsibility.

Meetings, Training, Stewardship Reporting: AIMS prides itself on providing the kind of pro-active Client service seldom seen in our industry. From in-person Client meetings to completing specialized data reports on the program development, we will always go the extra step. Our management staff is responsible for our in-service training. When requested, training sessions on proper reporting, new case law or changes in the methodology the State expects the delivery of workers' compensation services to be accomplished is an integral part of our value-added partnership. These training sessions may be held at our offices, Client locations or other specific areas designed to accommodate a number of our local Clients who share the same need for up-to-date status on the ever changing climate of workers' compensation in California.

As part of our philosophy with regard to continual and seamless communication with the City, we expect there will be times when agency or department heads will inquire about specific cases and the strategy for disposition. On those occasions and with the City's permission, we will schedule file reviews or in-person meetings to inform the department of progress on a specific claim(s). AIMS provides the City regular face-to-face meetings with the Examiner(s) at the City's desired location. Pre-meeting status reports are developed and any issue that is allowed to be discussed will be placed on an agenda. Privacy issues will be protected from those employees who are not authorized to discuss those topics.

Economic and Administrative Control Over Claims Costs: Our approach to the management of our Clients' claims and programs centers on quality, service and results. We are committed to a constant focus on these key elements of our *Loss Portfolio Management*® approach. Our Clients are not just the employers but also the employees who have sustained industrial injuries or illnesses while working within the course and scope of their employment. We focus upon promptly providing these employees the benefits due them and maintaining open and on-going communication with them during the course of their claims. Programs that provide this positive approach will produce lower overall workers' compensation costs, including significantly reduced litigation rates.

Loss Portfolio Management®: Our "*Loss Portfolio Management*®" approach ensures that we are always focused on identifying key issues that have a large financial impact on the overall claim and to proactively utilize all available internal and external cost containment resources to address and resolve these issues in an expedient fashion. **AIMS management and staff have a singular objective: assist the City to be productive and profitable while providing compassionate care of its injured employees.** We work in partnership with our Clients to achieve optimal results from their self-insured workers' compensation program. AIMS goes beyond ordinary third party administration services, to offer our Clients a customized, flexible loss management program and services designed to generate lower claims costs and better outcomes.

Quality Assurance: AIMS asserts a strong Quality Control Program, in which we consistently monitor, measure performance, and review the quality of the services being provided to ensure superior customer service and cost saving results for our Clients. In addition to the standard supervisory audit, our Internal Audit Unit, headed by Cheryl Agee (Vice President Workers' Compensation), conducts audits against our best practice standards as well as the Client's Special Handling Instructions. The Audit Unit's process

involves notification that an audit is to be conducted in the Branch or local office. The Manager makes available all requested information, claim files, logs, contracts, etc. In addition, the Manager participates in the actual audit itself. All files with deficiencies and/or recommendations are immediately returned to the Claims Examiner for corrective action. The Claims Managers review the file for compliance at each diary date. The Supervisors carry independent diaries for this purpose. Audit scores are incorporated into Performance Evaluations conducted annually for each employee. The audit conducted by our internal audit unit is comprehensive and takes into consideration all facets of claim file handling.

Diary System: The key to good claims management, avoiding penalties and keeping deadlines, is an effective diary system that enables the Claims Examiner to properly manage each claim in an expedient manner. Claims Examiners are required to review open Indemnity claims at least every 45 days. Our computer system has an automated diary system that is utilized by all of our staff. A detailed list of diaries is displayed each time a user logs onto the computer. At a minimum the claims unit supervisors are required to review open Indemnity claims within 10 days of a new claim filing and thereafter every 120 days. Our knowledgeable, dedicated managers and supervisors provide strong supervisory oversight. AIMS internal audit team reviews claims to assure legal and regulatory compliance, as well as conformity to best practices and Client-specific performance standards.

We employ a "supervisor's overview" of the daily diary to monitor when a file is due to be reviewed and whether or not the Examiner has conducted the diary. This is one of the key components of our internal audit process.

In addition to the standard supervisory audit, our own Internal Audit Unit (headed by the Vice President of Workers' Compensation), conducts audits against our established procedures as well as the Client's Special Handling Instructions. The Audit Unit's process involves notification that an audit is to be conducted in the Branch or local office. The Manager shall make available all requested information, claim files, logs, contracts, etc. In addition, the Manager shall participate in the actual audit itself. All files with deficiencies/recommendations are immediately returned to the Claims Examiner for corrective action. The Claims Managers review the file for compliance at each diary date. The Supervisors carry independent diaries for this purpose. Audit scores are incorporated into Performance Evaluations conducted annually for each employee. The audit conducted by our internal audit unit is comprehensive and takes into consideration all facets of claim file handling.

The following Time Performance Standards are part of our Best Practices audit standards, which are used to help keep claims on track for prompt resolution.

TASK	TIMEFRAME
Claim set up in Computer	Within one (1) working day of date of receipt
Initial Claimant Contact	Within one (1) working day of date of receipt

TASK	TIMEFRAME
Subsequent Claimant Contact	Every 14-days of continued disability – or every thirty (30) days if on modified duty
Initial Client Contact	Within one (1) working day of date of receipt
Initial Medical Provider Contact	Within one (1) working day of date of receipt
Initial Payment of Disability	Within fourteen (14) days of first day of disability
Investigation	Within five (5) days of knowledge of condition requiring investigation & approval by Client
Investigation Reports	Within fifteen (15) days of assignment – subsequent reports maximum of every thirty (30) days
DWC Benefit Notices	Within fourteen (14) days of the event causing the need for notice
Penalty Report Form	To be completed within 72 hours of notice of penalty-Form to home office within 5 working days
Penalty Payments	Self-imposed penalty to accompany delayed benefit
Auto Pay Schedules	Not to be authorized for more than seven (7) periodic payments (84) days
Advance Travel Expense	At least ten (10) days before examination date
Transportation Reimbursement	Approval for payment within fifteen (15) working days of request for reimbursement
Medical Treatment Billings	Approval for payment within ten (10) calendar days of receipt of bill
Payment of electronic bills	Within fifteen (15) days of electronic receipt
Contested medical bills	Notice to provider within twenty (30) calendar days that bill is contested, denied or incomplete
Payment of Awards, C & R's, stipulations	Approval for payment within fourteen (14) calendar days of receipt or Statutory Requirements.
Litigation	Referral to defense council no more than ten (10) days from date of decision to refer (sooner if impending court date or other deadline)
Initial status report from defense counsel	Maximum of fifteen (15) days from date of referral
Subsequent reports	Maximum of thirty (30) days from last report
Subrogation	Notification/Contact with negligent third party within thirty (30) days of determination of existence of subrogation
Balancing of Claim File	Every 180 days or end of benefit, whichever occurs first

TASK	TIMEFRAME
Excess Reporting/Reimbursement	Initial reporting—within ten (10) working days of date of knowledge that any reporting Criterion has been met
Requests for reimbursement	Maximum of every ninety (90) days
Case Closure	Within thirty (30) days of the final payment, notice, or as provided by law
Telephone Inquires	Return Calls—within one (1) working day of original telephone inquiry
Plan of Action Review	Every ninety (90) days a full plan of action update is noted in the system
Return Correspondence	Written answer completed and returned within five (5) working days of receipt
Supplemental Job Displacement Vouchers (Potential Notice)	Within 10 days of last payment of temporary disability
Conversion of Medical Only to Indemnity	Within one (1) day of knowledge that file needs to be converted and reviewed/approved by Supervisor
Reserves	At initial file setup Within seven (7) days for any event that triggers the need for a reserve change Reserve reviews required at a maximum of every ninety (90) days
Status Reports	Every ninety (90) days created and provided to Client
Examiner File Review	No less than every forty-five (45) days – documented by notepad activity under "Examiner review"
Supervisory File Reviews	At a maximum of every one-hundred and twenty (120) days

AIMS will customize these response times if the Client has specific requests and these will also be reflected in the Client Special Handling Instructions. These instructions will incorporate AIMS Best Practices (AIMS4Excellence), Case Review Details, and assertive quality control measures that include all Client specified timelines.

All of these standards and procedures, along with our hands-on proactive involvement in the claims, ensure cases continually move toward a timely and cost effective closure without jeopardizing necessary high quality of care for the injured worker.

AIMS Supervisors are focused on providing continuous oversight of the claims and Client programs. A monthly review is conducted on a percentage (minimum 10%) of each Examiner's files to ascertain that the Claims Examiner is performing up to our standard as well as the agreed upon standards of the Client. The Supervisor subsequently reviews claims at regularly timed intervals (not less than every 120 days) or when specific events

occur such as surgery or litigation, when the claim meets reserving or payment thresholds, and in the course of continuous random audits.

AIMS Supervisor has numerous duties including frequent reviews of Claim Examiner's claims. Supervisors do not carry caseloads as they are focused on providing continuous oversight of the claims and Client programs. The following are examples of Supervisor duties:

- The Supervisor will review all new losses received daily to confirm contact was made timely and make an entry in the computer's supervisor notepad.
- The Claims Management Information System will set an automatic supervisor diary for 10 days following claim entry to confirm that all issues on the claim have been addressed. (i.e., subrogation, notices, benefit provision, etc.)
- By the 6th business day of the following month the Supervisor will provide a report to the Branch Manager and corporate office outlining the total lost time claims received, the total timely contacts and the percentage of timely contacts.
- Each Supervisor is to monitor the payment diary of their staff for timeliness and accuracy.
- The Supervisor is to monitor the review diary of their staff for timeliness and accuracy no less than once a month.
- All denials and delays shall be approved by the team supervisor. Authority to delay or deny a claim shall first be obtained from the Client.
- As soon as suspect issues arise, they must be written up by the Claims Examiner and given to the immediate Supervisor with the file to be reviewed and consideration for fraud investigation will be made.
- Any file which indicates the possibility of subrogation should be forwarded to a Supervisor for review to determine if further investigation is required.
- Upon receipt of a Decision or Order, the Supervisor shall make a prompt analysis regarding an appeal. If the Supervisor feels the decision should be appealed, the file should be documented as to the reasons and referred to the Branch Manager.
- Upon receipt of the "Reinsurance Report" each Unit Supervisor or Branch Manager shall verify that all cases listed on the report have been reported to the Excess/Reinsurance carrier.
- All non-senior level Team member closures shall be approved by the Team Supervisor or Manager.
- In addition to the above duties, the Supervisor, as a part of his/her performance evaluation has to review a select percentage (minimum 10%) of each Claim Examiner's files on a monthly basis. This review is conducted to ascertain that the Claim Examiner is performing up to our standard as well as the agreed upon standards of the Client. For sensitive or high exposure cases, the supervisor utilizes a personal oversight diary, identifying those cases that warrant periodic management review. The Supervisor Review is clearly noted in the notepad.
- Appropriate action is taken to ensure completions of all tasks are met. Our Supervisors provide technical oversight of the individual claims and of the employers' workers' compensation programs, ensuring quality, service, results as well as compliance with regulatory and Client-specific program performance

standards. Supervisors do not carry a caseload. All Senior Claim Examiners and above are State certified to administer self-insured workers' compensation claims unless waived by the Client.

Monitor and Manage Case Loads: On a continual basis, we review the Claim Examiner activity dashboards that capture all new claims and closing ratios and pending open files. The Supervisors consistently manage the Claim Examiner's caseloads to ensure caseload levels are managed based on Client specific requirements. All files with deficiencies/recommendations are immediately conveyed to the Claim Examiner for corrective action.

AIMS is committed to fully comply with the regulations for Workers' Compensation Examiner Certification regulations (CCR, Title 10, Sections 2592 to 2592.14) that were developed to implement Insurance Code Section 11761 effective February 22, 2006.

Education and Training: Our management staff is responsible for conducting and/or coordinating all in-service training and our Vice President of Workers' Compensation (VP), responsibility includes monitoring for compliance with the Insurance Code 11761, training and continuing education, on a bi-annual basis. The VP currently publishes a schedule for each branch manager indicating who in the respective office is subject to the CEU requirement annually. It becomes the responsibility of the Manager to then arrange for outside CEU opportunities or arrange to schedule in-service seminars by inviting industry professionals into our offices to conduct DWC approved courses. All professional staff is invited as well as interested Clients.

AIMS pays for our Claim Examiners and Assistants to complete their Insurance Educational Association (IEA) certificate. We also pay for the Self-Insured Administrators test if the current position requires certification. We pay for outside seminars and conferences and provide the staff with frequent in-house educational presentations. AIMS recognizes the only way to ensure compliance with workers' compensation laws, regulations and statutes is to maintain a high level of continuing education and training in order to keep up with legislative, legal, and regulatory changes in our industry. We conduct training on a regular basis in the areas of subrogation, fraud, medical management and other key training areas within our Best Practices Performance Standards. At AIMS, we require all staff to attend and complete training sessions regarding legislative, legal and regulatory changes in the workers' compensation industry.

Partial List of Recent Mandatory Training Sessions: EDI Training, Utilization Review, Medicare Set-Aside Trusts, AMA Guides & PD Rating, Fraud Training, Medical Provider Networks, Security Awareness, 4850 & Public Safety Presumptions, Supplemental Job Displacement Benefits, Ergonomics, and Medical Roundtable.

Reserving: AIMS Claims Examiners are well versed in the tangible and intangible rationale affecting reserves and establish accurate reserves given the state of the claim facts at any point in time. Reserves are constantly reviewed at each scheduled diary. Reserve worksheets are prepared to support any changes made in reserving amounts and can be provided to the Client in support of a reserve increase or other change. This information is made available to the Client through online viewing of the Examiner's electronic file notepad. If the Client desires, prior to any reserve change of a pre-agreed

amount or level, the Claims Examiner will confer with appropriate Client personnel to discuss the merits of the proposed change.

AIMS Examiner will review and evaluate the reserve adequacy and possible closure at 45 day intervals or as designated by the City.

The criteria that mandates review of reserves is based on the level of authority by position. Provided below are the corporate guidelines applied to reserving as well as the task performance timeframes:

Examiner	$0	- $250,000
Senior Examiner	$0	- $500,000
Supervisor	$0	- $750,000
Branch Manager	$0	$1,000,000

Performance Time Frame Standards – Reserves

TASK PERFORMED	TIMEFRAME
Reserves	At initial file setup. Within seven (7) days for any event that triggers the need for a reserve change. Reserve reviews required at a maximum of every ninety (90) days.
Status Reports/ Plans of Action	Every ninety (90) days.
Supervisory File Reviews	At a maximum of every one-hundred & twenty (120) days.

Please see Exhibits 7 – Settlement Authority Request Worksheet and Exhibit 8 – AIMS4Excellence TOC

D. Ancillary Services: Identify any company-owned and affiliated ancillary services to include, but not limited to, bill review, and utilization review. Provide a description of each ancillary service including an organizational chart, physical location, description of where the work is being conducted, management structure, and number of employees. List all outside vendors you currently work with including the services they provide. If such services were awarded to one or more vendors not owned by or affiliated with your company, describe how your firm would work with such outside providers to ensure effective and efficient service to the City. Include any limitations you may have in working with outside vendors.

AIMS strives to provide its Clients with a thoroughly customized program. We provide assistance to our Clients in formulating customized claim report generation, customized stewardship reporting, a customized transition plan, customized Medical Provider Networks (MPN), customized Preferred Provider Organization (PPO) Networks, customized Carve-Out Programs to address cost drivers, customized utilization review (UR) and medical case management referral criteria, customized vendor panel, and in-

house customized training on workers' compensation topics and trends to name a few.

For medical cost containment services, AIMS recommends its sister company, Allied Managed Care, Inc. (AMC). AMC has been providing these services to California public agencies, self-insured's and insurance carriers since 1995. AMC offers Medical Bill Review, Utilization Review, Nurse Case Management (including telephonic and on-site or field nurse case management), Customized Medical Provider Networks (MPN), AlliedRx (Prescription Management), AlliedCare Complete (Early Intervention), and CallConnect (Call Center Services).

AIMS researches and will vet service providers for quality and best-value for our Client and will make our recommendations known to the City. If the City has preferences for various service providers, AIMS will use the City's preferred vendors. The service provider "panel" is pre-approved by our individual Clients. Any exceptions to appropriate assignments are managed on a case-by-case basis. Through this platform, we have the ability to streamline the Claims Examiner workflow as well as track, manage and run reports on service provider usage.

AIMS coordinates Clients' vendor panels and approvals in advance and all referrals to vendors in accordance with the Clients' requirements as part of an integrated cost containment solution, which entails managing ancillary services and coordinating programs such as:

- Medical Bill Review
- Utilization Review
- Nurse Case Management
- Return to Work (includes on-site programs),
- Loss Control
- Workplace Safety
- Occupational Health Clinics
- Job Task Banks
- Employee Training and Medical Provider Networks (MPN)

Also, AIMS continuously evaluates our strategic partner service providers to ensure performance-levels and continued value-add to our Clients.

AIMS has created an integrated referral platform called AIMS Rapid Referral Program (ARRP) to expedite this process of referral coordination between vendors and AIMS Examiners. The process integrates information directly from the Ventive System and uploads to the ARRP System. The ARRP System documents the referral and uploads the forms into the AX Document Storage System. The uploading and documentation of the referral eliminates the Examiners need to do these steps and instead completes these tasks upon creating the referral in the ARRP System. Reports are generated to track lag times and effectiveness of both the AIMS teams and the Vendors

E. Claims Management System: Describe in detail how your computer system is utilized to provide workers' compensation services. Discuss the capabilities of the system including whether the system tracks lost time, temporary modified duty and temporary partial disability. Provide samples of standard and customized computer-

generated reports you prepare for your clients (Note: limit 1 - 2 pages per sample).

AIMS utilizes Ventiv System, which is an Internet-based claims management system built on Microsoft.Net technology, designed for anytime, anywhere access. The system access is web-based and runs on an SQL database platform.

Our claim management system provides a wide array of information so, the City can immediately evaluate the current condition of its customized program. Access to this information allows the City to effectively manage its workers' compensation program and to confidently make high impact risk management decisions. Our system provides the City with extensive on-line capabilities for reporting claims, customized report generation, and immediate real time access to key information from any location.

Claim System Features of benefit to the City:

- Direct viewing of Claims System with description and details
- Key data at fingertips: financial data, claims diaries, notes, lost time, temporary partial disability, and RTW
- Self-Generated ad-hoc reporting when you need it
- User defined report queries
- Web-based entry of (Employers' First Report of Industrial Injury or Illness)
- 1099 reporting to the Internal Revenue Service
- Self-Insurers Annual Report generation
- Occupational Safety and Health Administration (OSHA) reports – Lost Work Days
- Electronic interface with the Index Bureau and Workers' Compensation Insurance System
- Production of all required reports and data exports (real time and viewed archived reports)
- Electronic Data Interface compliant
- Access all performance metrics (dashboard view)

AIMS claims management system accepts unlimited levels of location coding, allowing Client data to be sorted by location or cost center for loss control and financial purposes. The department names and organizational coding is customized to fit the needs of each Client. Similarly, custom code sets allow each Client to define their own tables, such as notepads, pay types, class codes, and job descriptions.

By customizing our coding tables, we are able to extract accurate and relevant data that satisfies the needs of each Client. The primary categories for reserves have been expanded to allow us to more effectively track benefit payment, reserve, and incurred data. The system tracks lost time, temporary modified duty, and temporary partial disability. Listed below are some of the reserve categories:

- Temporary Disability
- Permanent Disability
- Labor Code 4850
- Medical Expenses

- Legal Expenses
- Other Expenses (includes investigations)
- Vocational Rehabilitation Benefits

As mentioned above, the RMIS is upgraded on a continuous basis. Our claims information system utilizes state-of-the-art technology including access security, nightly back-ups with off-site storage, an uninterrupted power source to ensure continued use in the event of a power shortage, and a formal business interruption plan.

Access to our system is only gained through user specific security codes; therefore, only select personnel who have been given clearance have access to data and monetary functions. Various security levels are granted to users, which preclude change of data and generation of payment or reserve changes unless pre-authorized. Also, the system allows password security at the location code level so user can access only their location information.

Standard & Monthly Reports: In addition to extensive reporting, the following information is a sample of what type of reports and data AIMS Clients can view within the claims system: Claims Summary, Claims Examiner Notes, Detailed Payment Information, Detail Transaction, Managed Care (UR, Fee Schedule), Billing Information, and Prior TPA Information. In addition, correspondence such as medical legal reports, depositions, denial letters, and attorney correspondence information is also captured.

➢ AIMS electronic database is capable of producing specialized and ad hoc reports in addition to those required by the State of California. AIMS can provide various standard monthly reports and custom reports upon request. AIMS supports its Clients with a robust report library. Our system is an extremely powerful data management claims system for both standard and ad hoc report generation. Our web based system also provides convenience and access to real-time and "point in time" financials for generating customized Ad Hoc reports, multiple program reports for data downloads and monthly loss reports which can be exported into other applications such as Portable Document Format (PDF) or Microsoft Excel. Types of data available which will electronically be available to the County range from Claims Summary, Adjuster Notes/Diaries, Detailed Payment Information, Detail Transaction, Managed Care (UR, Fee Schedule), billing details to prior TPA information.

Please see Exhibit 10 – AIMS Sample Claims Reports

F. SAS 70 Audit Compliance: Indicate your firm's compliance with SAS70 annual audit compliance reporting and indicate the date of the most recent completed audit report.

AIMS undergoes SSAE 18 audits annually to ensure our controls are effective because we are very earnest about our business and the security of our Client's information. The Company has successfully undergone the audit process and is compliant with the Statement on Standards for Attestation (SSAE) No. 18, Reporting on Controls at a Service Organization.

The SSAE No. 18 audits effectively reports (SOC1 & SOC2 reports) on the relevant internal controls established by LJR Holdings, Inc. (LJRH) for AIMS, especially the financial controls and the information systems relevant to security, availability, processing integrity, confidentiality or privacy in performing our services for our Clients. The Company's compliant report for Service Organization Controls (SOC1 & SOC 2) has been included in the noted exhibit.

Please see Exhibit 11 – SSAE 18/ SOC 1 & 2 Reports (CONFIDENTIAL)

G. Client References: Provide a list of five (5) clients (including full contact information) from which similar types of claims-related services are provided by your proposed service team office. Include the length of your contract with each client including the approximate number of indemnity claims annually. The City will contact these references to discuss the bidder's performance.

The longevity of our Client relationships is based in part on the types of programs AIMS establishes, which reinforce the strategic goals of workforce excellence, organizational effectiveness, and fiscal responsibility. Provided below are references for Clients with programs similar to the City of Richmond.

REFERENCE – Claims Related Services	
Agency Name Central San Joaquin Valley Risk Management Authority (52 Member Cities JPA)	
Contact Name Kevin Werner, City of Ripon, City Administrator	
Contact Phone Number (209) 599-2108	**Contact Email Address** kwerner@cityofripon.org
Length of Contract / Number of Indemnity Claims Client since 1995 / 1000	

REFERENCE – Claims Related Services	
Agency Name City of Bakersfield	
Contact Name Jena Covey, Risk Manager	
Contact Phone Number 661-326-3090	**Contact Email Address** jcovey@bakersfieldcity.us
Length of Contract / Number of Indemnity Claims Client since 2007 / 500	

REFERENCE – Claims Related Services	
Agency Name City of Huntington Beach	
Contact Name DeAnna Soria, Risk Manager	
Contact Phone Number 715-536-5519	**Contact Email Address** deanna.soria@surfcity-hb.org
Length of Contract / Number of Indemnity Claims Client since 2010 / 500	

REFERENCE – Claims Related Services	
Agency Name City of Clovis	
Contact Name Lori Shively, Personnel/Risk Manager	
Contact Phone Number 559-324-2726	**Contact Email Address** loris@cityofclovis.com
Length of Contract / Number of Indemnity Claims Client since 2007 / 175	

REFERENCE – Claims Related Services	
Agency Name County of Madera	
Contact Name Jason Blanks, Risk Manager	
Contact Phone Number 559-675-7703	**Contact Email Address** jasonblanks@maderacounty.com
Length of Contract / Number of Indemnity Claims 2005 to present / 300 open claims	

Bill Review

A. Firm's Qualifications: Describe the firm and provide a brief statement of qualifications in providing bill review services. Describe your experience doing business with self-insured public entities in California. Discuss what distinguishes your company from other bill review providers. Provide a company-wide organizational chart with reference to the proposed service office and proposed service team.

AIMS recommends its sister company, AMC for bill review (BR) services. AMC has one central goal – provide professional medical cost containment solutions that result in improved program costs. AMC has over 100 Clients consisting of approximately 80%

self-insured public entities and 20% private entities throughout the continental United States and Hawaii. AMC audits approximately 230,000 bills per year.

AMC's philosophy is, in part, that the greatest net savings and not just the lowest fee bill review company should be any employers' decision point. Our goal is to ensure our Clients only pay what they are legally obligated to pay, no more or no less. Some competitors offer an extremely low fee and, to do so, they also automate nearly all of the bill review process. Fully automating BR leads to an increase of inquiry and dispute calls from the provider to the TPA/Employer, an increase in provider litigation (liens), and ultimately an increase in claims cost because of inaccurate and unjustifiable bill reviews.

Qualifications: As a full-service medical BR company, AMC adjusts medical, hospital, surgical and pharmacy bills using the Official Medical Fee Schedule (OMFS), the Official Inpatient and Outpatient Fee Schedules, and we apply discounts generated by MPN, Preferred Provider Organization (PPO) and pharmacy networks.

AMC does not simply "process" medical bills by pushing them through scanning and OCR technology for repricing, rather our certified bill reviewers manually review each and every bill in order to ensure we are recommending the most appropriate fee for the services provided. We strive to obtain the highest net savings for our Clients.

AMC Distinguishing Features: Our approach to the management of our Clients' Medical Bill Review programs center on quality, service, and results. AMC is committed to a constant focus on these key elements and provides these services in accordance with the California Labor Code and California Code of Regulations.

- A paperless single source solution for BR processing
- Director of Client Services (single point of contact)
- Over 20 years of expertise in California public entities including but not limited to having over 65 Clients that have **safety officer employees** and over 30 school districts. We have firsthand knowledge of the claim exposures, which allow us to effectively utilize all cost containment measures.
- Offer a variety of PPO's with the ability to geographically assess the best PPO
- Enforcement of UR determinations/interfaced with BR
- Health Insurance Portability and Accountability Act (HIPPA) Compliant
- Electronic document storage and retrieval
- Claims Examiner ToolBox (Web-based portal) – Electronic Claims Examiner Approvals/Objections

AMC maintains a partially manual process to ensure the ability of the BR analyst to verify via reading the corresponding medical reports the services billed were actually the services provided.

- Higher savings
- Improved accuracy
- Less provider disputes
- Less lien litigation

Enhanced Value for our Clients:

- Experience/Stability
  - California focus and expertise
  - Over 21 years' experience providing bill review/utilization review services – *California public and private entities*
  - Mandatory ongoing continuing education - effective solutions and increased cost containment savings
  - Fully licensed/dedicated technical staff
  - Managed care professionals collectively has over 100 years of experience
  - Management structure
  - Proven savings results
- Consistent superior audit results
- Client specific customization of programs
  - Customized Special Account Instructions based on the Client's requirements for desired results
  - Special Handling Instructions Allied Customer Expectations (ACE)
  - Customized protocols based on Client's requirements
- Innovative programs for cost effective handling of medical cost containment programs
  - Dedicated Client Services Director – single point of contact
  - Paperless Process – increased productivity, security/management
  - Excellent references

AMC BR Service Office and Org Chart: 10360 Old Placerville Road, Sacramento, CA, 95827.

A company-wide organizational chart has been included in the exhibit noted below.

Please see Exhibit 1 – Organizational Charts

B. Service Team Qualifications: Provide a brief summary of the qualifications and experience of each proposed team member, including their length of service with your firm and their resume. Provide an organization chart representing your staff and identify any sub-consultants you plan to utilize to supplement your proposed staff.

The AMC BR team identified below is supplemented by an extensive management, technical, and support staff in multiple offices located throughout the continental United States and Hawaii. Listed below are key personnel and members of the AMC Corporate Team. We do not use sub-consultants for the identified BR services.

Mark Denison, Senior Vice President of Operations: Mark oversees the entire customized Bill Review/Utilization Review/Nurse Case Management Program. Mark's role is to monitor all contract compliance with performance standards, audit compliance to individualized *Special Account Instructions;* legal and regulatory compliance; and provide ongoing communication with our Clients. Mark provides unparalleled leadership and direction to all AMC staff. He oversees all operational and administrative components of Allied Managed Care's services, including Medical Bill Review, Utilization Review, and

Case Management. He has over 23 years of experience in workers' compensation cost containment, strong multi-jurisdictional managed care knowledge and practical application. His involvement ensures that our Client's performance standards are met and communication is ongoing. Mark is always available to meet with our Client's staff to discuss issues and performance when requested to do so. Mark is a state board certified licensed Chiropractor, Certified Disability Evaluator and past Division of Workers Compensation (DWC) appointed Qualified Medical Evaluator (QME). Mark joined the AMC team in 2008.

Lea Morales-Mendez, Director of Client Services: Lea has over 26 years of workers' compensation experience in roles of operations and management as well as Client Services. Lea has received training in Disability Management, Health Insurance Portability and Accountability Act (HIPAA) and Utilization Review Accreditation Commission (URAC). Lea's role is to assist the management team in addressing all issues related to the contract as well as serving as a resource for workers' compensation decisions that may affect our Client. As well, as interacting with AMC's management team to resolve all issues that may arise in UR and Bill Review; provide timely communication to the management staff of any critical developments that may affect the product delivery; meet regularly with the management team to assess AMC's performance; discuss business decisions, and address concerns. Lea is a resource for our Clients. Lea joined AMC in 2006.

Melissa Miller, Bill Review Director: Melissa has over 20 years of experience in the industry including working for large national bill review companies. Melissa is a California Designated Bill Reviewer. She provides supervisory oversight and quality control of the entire medical bill review process for our Clients to ensure timely processing of payments. Melissa is responsible for all administrative and operational components of the bill review unit, including staffing, training, quality, timeliness and accuracy of work performed in the unit, ensuring efficient and optimum workflows. She has a working knowledge of the entire bill review process, from bill entry, tracking of bills in and out of the office, review of all bill types, check-offs, invoicing, export file generation and sending, report generation according to the *Special Account Instructions*, the re-evaluation process and the lien process. Melissa joined AMC in 2009.

Darcy Olivares, Bill Review Supervisor: Darcy is a California Designated Bill Reviewer with over 16 years in the workers' compensation industry. She reports to Melissa and is responsible for all administrative and operational components of the bill review unit; including staffing, training, quality, timeliness and accuracy of work performed in the unit, efficient and optimum workflows, and maintaining the positive and professional attitudes of unit members. Darcy also has a working knowledge of the entire bill review process, from bill entry, tracking of bills in and out of the office, review of all bill types, check-offs, invoicing, exporting files, report generation according to *Special Account Instructions*, the re-evaluation process, and the lien process. Darcy joined AMC in 2007.

Please see Exhibits 1 – Organizational Charts and Exhibit 4 – Team Resumes

C. Services: Describe your bill review services, features of your system, unique capabilities, and ability to customize the delivery of your services. Provide an

organizational chart, physical location, description of where the work is being conducted, management structure, and number of employees. Discuss your ability to work with TPAs in delivering bill review services and provide a list of three (3) you currently work with. Include your average monthly bill volume processed by your office.

AMC brings innovative medical cost containment programs for cost effective management at the onset of all claims. These programs include appropriate medical case management, formal customized utilization review programs, medical bill review, Medical Provider Networks, Preferred Provider Networks, and all necessary ancillary services to maximize all areas of medical cost containment to bring real savings back to the Client. We bring paperless single source solutions for utilization review treatment planning and bill review processing.

Average monthly bill volume processed by your office: AMC processes approximately **21,350** (3/1/21 – 2/28/22) bills on average per month in California. As the current Bill Review services provider, AMC has reviewed **9,556** Bills between 3/1/21 – 2/28/22 for the City of Richmond**.**

Third Party Administrators: AMC provides BR services through the following TPA's: Acclamation Insurance Management Services (AIMS), TRISTAR, and several self-insured/self-administered programs.

AMC's Bill Review Services

Client specific customization of programs: AMC develops a customized Allied Customer Expectations (ACE) for each Client and for each cost containment service. The ACE document outlines all expectations and any special requests of the Client that is required of AMC in order to comply with contract requirements.

- Customized Special Account Instructions based on the Client's requirements
- Special handling instructions detailed in the ACE service document
- Customized protocols based on Client's requirements

AMC Clients benefit by having a single point of contact, our Director of Client Services who is available to our Client to develop and maintain specific strategies ensuring proactive program management and compliance with all Client's requirements. We understand medical cost containment programs for public agencies. We have firsthand knowledge of the claim exposures, which allow us to effectively utilize all cost containment measures.

Innovation: These innovative programs include services to maximize all areas of cost containment and bring real savings to the City.

- **Single Source Solution**: AMC will provide paperless single source solutions for BR processing and UR treatment planning.
- **Director of Client Services**: AMC will provide a Director of Client Services (single-point-of contact) for the City to develop and maintain strategies to

ensure proactive program management and compliance with the City's requirements.

- **TPA Insight**: We understand medical cost containment programs for public agencies. We understand the requirements, specific procedures and overall goals of the City. Having AIMS, a workers' compensation claims administration firm, as our sister organization, AMC management is uniquely informed and experienced in designing programs that improve claims administration workflows and reducing costs while improving injured employee outcomes.
- **Best Suited PPO**: AMC does not own its own PPO, therefore, AMC can provide an objective analysis as to the best suited PPO.
- **Interface between BR and UR**: AMC has an established interface between BR and UR. We have had this in place for over 8 years, many years before it was recognized by the industry that it is a critical component to cost containment.
- **Education**: A key aspect of our services has been educating the Claims Examiners of the importance of timely submissions, appropriate UR referrals and full documentation. Educating the Claims Examiners on SB863, ensuring they understand their responsibilities and the penalties that apply as well as the proper workflow. Training is provided to the TPA by our Medical Director, Alan Randle.
- **Medical Director**: AIMS/AMC's Medical Director, Dr. Randle provides oversight, leadership, and medical expertise to all Managed Care Services provided by AMC. Dr. Randle has served as our Medical Director since 2008.

AMC's BR services include but are not limited to:

- Fee Schedule and/or Usual & Customary Review
- Duplicate bill detection
- Offer a variety of PPO's with the ability to geographically assess the best PPO
- PPO re-pricing and administration
- Code review and re-bundling of services
- Inpatient line-item audit reviews
- Outpatient line-item audit reviews
- Complex, specialty, and rush processing
- Enforcement of UR determinations/interfaced with UR
- National Bill Review Service
- Pharmacy review/PBM services
- Explanation of Benefits with appropriate State language
- Hearing Representation at no cost
- Negotiated Discount Services
- Guaranteed turnaround time
- Interface with claim systems or overnight pick up
- Health Insurance Portability and Accountability Act (HIPPA) Compliant
- 100% audit of reviews
- Electronic document storage and retrieval
- Examiner ToolBox (Web-based portal)

- Flexible account structure, customized work flows
- Provider inquiry explanation and resolution
- Extensive management/savings analysis reports (choose from a wide range of reports to gain instant access to important data)
- Data reporting to State regulatory agencies (AMC is State reporting and electronic billing compliant)

AMC's Software Platform: AMC can provide a state of the art BR program that utilizes a highly sophisticated software platform enhanced by the expertise of the dedicated AMC Client team trained to review bills in accordance with the specific requirements of the Client. The features of our system can be customized for each of our Client's unique needs and specific reporting requirements.

Our analysts use a web-based, automated system to generate accurate reviews and maximize savings. AMC identifies treatment that is not appropriate under American Medical Association (AMA) guidelines, monitor and identify duplicate bills and adjust medical, hospital, surgical and pharmacy bills using the updated and accurate Official Medical Fee Schedule (OMFS), the Official Inpatient Hospital Fee Schedule, and apply discounts generated by the MPN and PPO providers. Our BR software is updated on a regular basis to reflect current fee schedules and PPO networks. Our qualified trained staff reviews each bill to determine appropriateness of treatment and to ensure provider compliance with fee schedule ground rules. AMC will provide a paperless single source solution for the processing of all medical bills through scanning technology hardware.

In addition to the distinguishing BR features previously described in this proposal provided below are capabilities unique to AMC.

➢ **Integration of Bill Review and Utilization Review**: The electronic interface between AMC's BR and UR/Nurse Case Management is already established. When BR and UR share data, greater savings and better medical control result. Additionally, the electronic interface between AMC's managed care services to the AIMS Claims System is already established. Because these interfaces are already established, there is no delay in taking control of the medical cost containment aspect of a Client's program. The Client can be confident that this aspect of their program is not only in place, which often never happens on unbundled programs, but has been in place for many years with workflows streamlined and perfected over time.

AMC's system ensures integration of real time current information and communication on all claims is available to all cost containment practices/specialists through shared screen access. All UR and case management decisions regarding treatment limits and authority are placed directly into the BR software for retrieval and review during the audit process of all incoming bills. The Claims Examiner and/or telephonic nurse case manager can easily determine if retrospective UR is potentially needed based on AMC's advanced ability to electronically return medical bill review information sorted by prior prospective or concurrent UR involvement. In other words, integrated platform ensures, on an automated basis, that services approved are the services paid.

If treatment that was never requested or authorized is billed, the BR system will flag the treatment and allow the Claims Examiner and/or telephonic nurse case manager to send the treatment through UR for a retrospective look at whether the treatment is authorized or denied.

Reports: AMC is able to track trends for Clients by providing numerous BR reports including savings reports, PPO savings, and penetration reports, provider savings, duplicate billing, claim charges, top billers, hospital reviews, and many more. The City can also request ad-hoc reporting to meet specific needs. A wide variety of reports are available to the City and can be run on any schedule required. These reports can be generated in multiple formats including: PDF, Excel, RTF, HTML, etc. The reports include information such as claim number, provider, dates of service, billed charges, recommended allowances, etc.

Quality Assurance: AMC provides quality assurance in medical bill review on several levels as follows:

1. An override report is run at the end of each business day, to determine that all overridden bills were checked for duplicates.
2. A retrospective Quality Assurance ("QA") is performed using reports that identify all bills reviewed by each analyst**.** QA is performed during the daily functions while researching bill history and processing of Add-recs. The QA is performed by the senior analysts and supervisors on a daily basis. The following is an abbreviated list of the QA points that are stringently looked at:
    - Keying – ensure bill data and demographics has been correctly added into the system.
    - Claim – ensure the bill has been processed against the correct claim.
    - Reductions – whether correctly taken or calculated.
    - Reports – ensure all required reports are attached.
    - Negotiated Discounts – ensure negotiated discounts have been applied.
    - Treatment Plans – confirm the treatment plan has been followed.
    - Vendor/Provider – confirm the correct vendor/provider has been selected for payment purposes.
    - Billed Charges – confirm all attached billing documents and charges are for the same patient and from the same vendor/provider while ensuring no charges are missed.
    - Coding – ensure correct diagnosis, service codes and DOS are entered.
    - EOR Message Codes – ensure the message codes applied are applicable to the services being reviewed.
3. Results are addressed with each individual analyst, noted as part of their production standards, and are logged for monthly reporting as well as performance review.
4. Results are further utilized for individual and group training sessions.
5. While conducting a QA audit, should an AMC error be discovered, our Client will not be charged for the correction and a new EOR will be sent to our Client.

6. All found issues are provided to the Manager of BR who maintains spread sheets of production counts and errors. This data is used for the monthly reviews of the analysts and to determine where additional training is required.

AMC's turnaround time averages four (4) days: AMC's average company turnaround time is four (4) days. It is important to define and explain AMC's turnaround time guarantee. Sometimes, a bill cannot be properly reviewed without additional information. Approximately 8 - 12% of bills received fall into this category for any number of reasons beyond AMC's control. The AMC guarantee speaks directly to the timeframe once a bill arrives in the AMC office which has no issues relating to the accuracy of the information on the bill or the completeness of the bill.

AMC adjusts medical, hospital, surgical and pharmacy bills using the Official Medical Fee Schedule, the Official Inpatient and Outpatient Fee Schedules, and applies discounts generated by PPO and pharmacy networks. At AMC we don't just don't run the CPT codes as billed by the provider. In our process each bill is looked at to ensure that documentation supports the level of service being billed.

Negotiated Bills: AMC's pro-active approach to maximizing potential savings is demonstrated in AMC's practice that dictates we send fee schedule exempt bills as well as non-PPO bills to the negotiation unit within the AMC BR department. This unit is able to negotiate additional savings beyond PPO discounts and/or in place of when no PPO reduction is applied by the specific PPOs. The Negotiation Unit has been building relationships with providers who are now submitting requests directly for additional savings and prompt payments. Savings are obtained by way of LOAs (letters of agreement) that apply when a 7-10 day turnaround on payments are made.

Additionally, all bills, regardless of status, that are in excess of $2,000.00 (after reductions) are reviewed for potential referral to the negotiation unit. It should be noted that our Clients pay only a percent of these additional savings, if we achieve savings above and beyond the fee schedule. Simply put, if no additional savings are achieved, our Client pays nothing for our review. Currently, our Negotiation Unit is averaging a 10% savings for our Clients.

AMC routinely negotiates fee reductions on bills meeting standard criteria (including in-patient hospital bills, surgical procedures, and other high dollar exposures) that fall outside our contracted PPO Network. Our negotiation approach, which includes signed negotiation letters by both AMC and the medical provider, serves two purposes:

1. Acceptance of payment as full and final payment (eliminating lien potentials).
2. Additional savings below Fee Schedule allowances (or in place of) for expanded Bill Review savings for our Clients.

Automated Recalculation of Savings and Fees of Duplicate Bills: When AMC displays data that is for additional allowance recommendations on previously reviewed bills, the billed charges are shown as zero (which is accurate) and the "savings" is shown as a negative number. In this way, we do not artificially inflate the billed charges and our total savings is actually reduced, so that at the end of each month our Client sees a true

"net" savings. If our Clients BR fee was based on a percent of savings, then AMC recalculates the full BR fee and refunds the appropriate amount based on the updated savings on the bill. Any reconsideration with a credit to our Client is done automatically in the system. Our Client does not have to rely on the manual intervention on an individual which may be subject to error.

Unbundling is a significant cost driver that is virtually overlooked by many BR systems. Embedded in our software platform are bundling criteria from multiple sources, including Correct Coding Initiative (CCI), AMA, and American Academy of Orthopedic Surgeons (AAOS). The system is able to identify inappropriate billing patterns through logging vendor ID numbers associated with bills that are up-coded, bundled, fall outside medical treatment guidelines, and/or exhibit excessive fees. A report is then generated to reflect these providers so action can be taken if indicated. AMC's system reviews all CPT ranges but we pay special attention to CPT codes in the range of 97010-98778 and 98940-98943 because of the mandated limits on physical therapy and chiropractor treatments. AMC's system generates an automatic alert indicating the 24-limit visit rule has been exceeded.

Provider Networks: AMC can provide both MPN and PPO, to be used exclusively by our individual Clients. These workers' compensation specific networks incorporate the medical providers with extensive, specialized experience in dealing with injuries incurred at the work place or job site. AMC does not own its own PPO, therefore, AMC can provide an objective analysis as to what PPO is best suited for the Client.

Allied Managed Care Service Entity Medical Provider Network (MPN): The Division of Workers' Compensation Medical Unit for the Allied Managed Care MPN, MPN Identification Number 2360. The approval is for a period of four (4) years. Allied Managed Care Network is filed as a "Network Service Entity" which means that we can add the City without having to refile with the state, saving many months for implementation.

On 2019 AMC received re-approval (#2360) from the Department of Industrial Relations, Division of Workers' Compensation Medical Unit. This approval is valid for a period of four (4) years.

As a "Network Service Entity" AMC offers Clients:

- Only one filing
- Less customization
- Only one website
- Only one audit
- Better control of Network

Preferred Provider Organization (PPO): AMC has an ever-growing list of PPO's to offer and will work with the City to determine the best PPO's for the City's program. Our broad menu of network relationships is designed to offer our Clients the ability to match their own experience with the PPO option that would maximize cost effectiveness. By not being tied to or owning any PPO network we avoid the potential for a conflict of interest when selecting the best PPO for our Client.

Additionally, the system allows several ways in which we can maintain and support Client specific contractual discounts. AMC can load virtually any PPO or negotiated fee arrangement by individual provider, into the BR software engine for automated application of discounts.

We work with the Client to determine the best PPO. During the transition phase, we discuss the PPO options. We are able to use the provider zip codes from our Client's most recent BR data to let our Client know which PPO offers the most coverage in its area. Ultimately, the Client will choose which PPO provider we use. The Client may select access to one, two or three PPO's. If more than one is selected, the PPO's are then categorized in our BR system as primary, secondary and tertiary.

Provided below is a partial list of some of the available PPO networks:

- Blue Cross – CA
- First Health / Coventry
- Procura
- PRIME
- InterPlan
- ClarisPointe
- ASI Flex

Lesser of Language: In order for a PPO Network to be utilized by AMC for its BR services, the contract must contain the "Lesser of Language", which allows the reviewer to apply the lesser of fees between Fee schedule and the PPO contract.

Pharmacy Program: AMC can track narcotic prescription drug usage and recommend UR and/or Medical Case Management to work with the prescribing physician and injured worker to establish an alternative treatment course to avoid the potential for addiction and abuse.

Integration with PPO, MPN, UR, and PBM Programs:

- AMC's BR System has a variety of PPO's a Client can choose from and AMC can also cascade up to three PPO's to assure maximum savings for our Clients.
- AMC will load the Client's specified MPN providers and discounts into the Bill Review System so MPN providers are assured appropriate payment.
- AMC BR System can accept UR determinations from UR companies to assure only treatment approved will be paid. AMC can provide the City's UR Company a layout of needed information in order to accept the determination in the BR System.

AMC has an Approved Ancillary Networks Panel: AMC has gone through an extensive process of researching and interviewing numerous ancillary network vendors in order to establish a complete ancillary network vendor panel which will give our Clients the best possible service. AMC does not receive any fees for referrals to the AMC Ancillary Network Panel vendors. Any discounts received are based upon AMC's collective buying power and passed through to our Clients. Our Clients can use the AMC networks, or AMC will work with any network preferred by the Client.

Provider Inquiries Bill Review: Provider/vendor inquiries or appeals are received via phone, mail and fax regarding underpayments and/or denial of reviewed bills. Phone calls are returned within 24 hours. Inquiries that come through the mail are distributed within 24 hours of receipt. If the inquiry is an appeal, that appeal will be completed within 30 days. Each appealed bill is reviewed against the claim history to determine if the bill was paid correctly on the initial review, processed under a different document control number (DCN) or processed if the missing information/documentation is attached for further review. Upon completing an additional or follow-up review, the results are sent back to the provider via an EOR or letter.

Independent Bill Review (IBR): We work with each Client in determining the best process by which to manage the Second Requests as well as the IBR determinations. As each Client has a different workflow process, we have a questionnaire that we will complete with our Client in order to determine the best way to manage the process.

A testament of Quality Bill Review is demonstrated by AMC's Bill Review error of less than 1% and the fact that AMC has only received a total of four (4) IBR's from the inception of the IBR process.

AMC Implementation of Request for Second Review

1. AMC can create either pend or denial rules based on proposed time frames. Determination of which type of rule will be upon Client request.
2. AMC has created specific message codes to be utilized in conjunction with the legislation.
3. Tracking of the 14 day response timeframe to the provider can be managed by the Client in a variety of ways including the creation of specific Bill Review queues, assignments to work specific pend queues, and use of reports.
4. Any current Penalty and Interest reports will be updated to include the time frames for Request for Second Review.

Lien Resolution: AMC works together, at no additional cost, with any representative appointed by the Client to resolve a lien. The Bill Review Re-Evaluation Specialist advises the Claims Examiner as to the process by which the bill was reduced (OMFS or which specific PPO was applied) so this information can be passed along to the lien claimant and defense counsel if the claim is litigated. In the event of a lien trial, if paper documentation of our process does not suffice, the Bill Review Re-Evaluation Specialist is available to attend the trial to testify and will appear as needed for expert testimony at no additional cost. We try to prevent billing disputes through a thorough re-evaluation process.

Physical location and number of employees: AMC provides all of its managed care services out of its office located at 10360 Old Placerville Road, Sacramento, California 95827.

As of February 2021, AMC has approximately 69 employees.

Org Chart: As requested a company-wide organizational chart with reference to the proposed service office and proposed service team has been provided in the noted exhibit.

Please see Exhibit 1 – Organizational Charts

D. Client References: Provide three (3) client references for your firm for which you provide bill review services including full contact information.

REFERENCE #1 – Bill Review	
Agency Name County of Los Angeles	
Contact Name Alex Rossi, MBA, ARM, Workers' Compensation Contract Administrator	
Contact Phone Number (213) 738-2154	**Contact Email Address** arossi@ceo.lacounty.gov
Brief Description of Scope of Services All Managed Care Services / Client since 2006	

REFERENCE #2 – Bill Review	
Agency Name Central San Joaquin Valley Risk Management Authority	
Contact Name Kevin Werner, City of Ripon, City Administrator	
Contact Phone Number (209) 599-2108	**Contact Email Address** kwerner@cityofripon.org
Brief Description of Scope of Services All Managed Care Services / Client since 2012	

REFERENCE #3 – Bill Review	
Agency Name City of Bakersfield	
Contact Name Jena Covey, Risk Manager	
Contact Phone Number 661-326-3090	**Contact Email Address** jcovey@bekersfieldcity.us
Brief Description of Scope of Services Workers' Compensation Claims Administration and Managed Care	

REFERENCE #4 – Bill Review	
Agency Name Schools Insurance Group SIG	
Contact Name Gabrielle Daniels, Director of Claims and Loss Prevention	
Contact Phone Number 530-823-9582 X208	**Contact Email Address** gabbid@sigauburn.com
Brief Description of Scope of Services Workers' Compensation Claims Administration and Managed Care / Client since 2013	

Also, all requested References have been detailed in Exhibit 5 - Client References

Utilization Review

A. Firm's Qualifications: Describe the firm and provide a brief statement of qualifications in providing utilization review services. Describe your experience doing business with self-insured public entities in California. Discuss what distinguishes your company from other utilization review providers. Provide a company-wide organizational chart with reference to the proposed service office and proposed service team.

AIMS recommends its sister company, AMC who has been providing expert Utilization Review (UR) Services since 2005. AMC conducts over 30,000 utilization reviews per year. AMC has over 100 Clients consisting of approximately 80% self-insured public entities and 20% private entities throughout the State of California.

AMC's Utilization Review Service Qualifications

AMC has developed a customized efficient method to handle UR referrals, meet mandated timelines for decisions, handle Peer Review and appeals, and communicate with all parties. This information is captured in a responsive and results oriented Policy and Procedures Manual. This manual outlines the metrics AMC uses to ensure a high standard of quality for products and services provided to our Clients.

Accompanying the Policy and Procedures Manual is a proprietary document called, Allied Customer Expectations (ACE). AMC develops a customized ACE for each Client and for each cost containment service. The ACE document outlines all expectations and any special requests of our Client that is required of AMC in order to comply with contract requirements.

Superior Audit Scores: AMC is very proud of our exceptional services being verified by the State, which is reflected in AMC's State Audit high scores for the past five years.

Independent audits have been performed by the California Department of Workers

Compensation; Statement on Standards for Attestation Engagement No. 18 (SSAE 18); and Utilization Review Accreditation Commission (URAC). AMC consistently performs well above the standard level of acceptability; as shown in our recent DWC audits. We also perform extensive in-house quality assurance audits on our employees' work product and processes.

URAC Accreditation: Since 2010, AMC has been awarded Workers' Compensation Utilization Management Accreditation from Utilization Review Accreditation Commission (URAC). As of October 2019, AMC received a 100% score on the recertification and has been approved for an additional three (3) years. This recertification ensures AMC is consistently providing services at URAC standards.

In 2016 with the passing of SB 1160, URO's will be required to be accredited in Utilization Review: *"The bill would, commencing July 1, 2018, require each utilization review process to be accredited by an independent, nonprofit organization to certify that the utilization review process meets specified criteria, including, but not limited to, timeliness in issuing a utilization review decision, the scope of medical material used in issuing a utilization review decision, and requiring a policy preventing financial incentives to doctors and other providers based on the utilization review decision."*

Beginning nearly ten years before this legal requirement, AMC invests time, resources and money year after year to be URAC accredited in order to protect the interests of our Clients and their employees.

URAC, an independent, nonprofit organization is a leader in promoting health care quality through accreditation and certification programs. The URAC standards keep pace with the rapid changes in the health care system, and provide a mark of distinction for health care organizations such as AMC to demonstrate their commitment to quality and accountability. This certification and URAC audits of AMC is a benefit to our Clients by providing third party assurance that we are in full compliance with data integrity, Health Insurance Portability and Accountability Act (HIPAA) requirements, proper credentialing. Through its broad-based governance structure and an inclusive standards development process, URAC ensures that all stakeholders are represented in setting meaningful standards for the health care industry.

AMC is driven toward continual improvement of services by applying quality metrics and benchmarking to ensure we achieve top-quality performance consistent with the URAC Workers' Compensation Utilization Management Accreditation. Obtaining URAC accreditation demonstrates Allied Managed Care's commitment to providing quality services for our Clients to help ensure that injured workers receive the best and most appropriate care.

Client Module – *AlliedConnect*: An important Part of the UR lifecycle is the Claims Examiner approval process. AMC has developed our own UR platform, *AlliedConnect* with the understanding that it must be user friendly for Claims Examiners. Having a TPA such as AIMS as our sister company, provides AMC with a strong understanding of the "pain points" a Claims Examiner can experience when processing Utilization Review requests. AMC's *AlliedConnect* – Client Module is a fully integrated software, automated to help the Claims Examiner approve and distribute appropriate UR requests when

needed. Our proprietary system includes an easy referral process to AMC's UR when appropriate. All Claims Examiner UR approvals and AMC Utilization Review determinations are captured, tracked, and electronically delivered to our BR platform for enforcement and payment.

Training: We hire and train the best people and streamline all systems and processes to support that goal. We provide our Client's Claims Examiners with the training necessary to authorize treatment requests that fall within pre-approved screening criteria. We also insist that our UR managers and directors attend all Department of Workers' Compensation (DWC) seminars and conferences to stay current on the constantly changing UR process.

AMC offers assistance to Claims Examiners in making first level UR decisions by providing utilization "Trigger Lists", and on-going training. Our in-house staff of nurses is trained to review additional medical information and make decisions, within accepted guidelines, regarding treatment specific to each individual employee. For those decisions which are more advanced or when treatment may not be medically necessary, AMC escalates the referral to one of our many peer panels for a physician's decision.

Licensed Nurses and Physicians: AMC has only licensed nurses and physicians performing all Utilization Review services that go beyond the Claims Examiner. No non-professional staff authorizes treatment or requests referral to Peer Review. The AMC UR Program operates under the direction of the Medical Program Director who is a California-licensed physician. Physicians that serve to evaluate treatment plans are licensed and board-certified with experience both as practicing physicians and in managed care/medical management. Specialty appropriate physicians are assigned to evaluate and make recommendations on plans of care.

First level reviewers (nurses) must be health professionals with a current, valid and unrestricted license, and have their credentials verified on an annual basis. Our Utilization Review Nurses must be licensed as either a Licensed Practical (Vocational) Nurse (LPN, LVN), or a Registered Nurse (RN).

Our UR team evaluates planned and provided medical care for necessity, frequency, and duration through services that include:

- Pre-Certification/Pre-Authorization reviews
- Reviews performed by our medical director and specialty peer review network
- Reviews based on national evidence-based treatment guidelines

Utilization Review process are compliant with 8 CCR §9792.9 (l) wherein treatment requests will not be denied on the basis of a lack of information without documentation reflecting an attempt to obtain the necessary information from the physician or from the provider of goods or services identified in the request.

Training: A key aspect of our services has been educating the Claims Examiners of the importance of timely submissions, appropriate UR referrals, and full documentation. Educating the Claims Examiners on current legislation, ensuring they understand their responsibilities' and the penalties that apply as well as the proper workflow. AMC's UR workflow is outlined in a diagram and has been included as an exhibit. Training is provided

to the TPA by our Medical Director, Alan Randle on a yearly basis or as needed with legislative updates.

Satisfaction Surveys: Client satisfaction surveys are conducted annually by the Director of Client Services using a survey instrument that encompasses issues of access, satisfaction with UR decision-making, turnaround time, and AMC's Client service. The survey data is collected and analyzed by the Client Services staff and is shared with all departments. The survey results and action plan are presented to the Quality Management Committee and the Vice Chairman of the Board, who may modify or add to the plan. The results of the corrective action plan are monitored by the Quality Management Committee and Vice Chairman of the Board.

Medical Director: AIMS/AMC Medical Director, Dr. Alan Randle, who is a California-licensed physician is actively involved with not only AIMS/AMC, but also with our Clients. Dr. Randle will work with the City to develop a mutually agreeable process for oversight of the Claims Examiner approvals and will be actively involved in the appropriate training or the claims staff in the authorization process to recognize the most appropriate claims for medical case management services.

Dr. Randle received his medical degree from the University of San Francisco in 1973. He completed his residency in Seattle, Los Angeles, and Cincinnati with a focus on general surgery and occupational medicine. Dr. Randle became certified by the American Board of Preventive Medicine in Occupational Medicine in 1989. Dr. Randle practiced Occupational Medicine while Vice President of RediCare Industrial Medical Clinic through June of 1991. Dr. Randle is board certified in Occupational Medicine and has ultimate oversight of all UR department decisions; education of nurses and Examiners regarding UR rules and regulations. He stays abreast of current changes in legislation and trains staff on new regulation. Dr. Randle is also the Chairperson of our Quality Management Committee and is accountable to the corporate President & CEO and Senior Vice President.

Dr. Randle has over twenty (20) years of experience with the practice of occupational medicine. This experience encompasses the clinical practice of medicine, medical evaluation, management, and academia. Dr. Randle is a noted industry expert in California Utilization Review. He is a presenter and instructor to physicians, claims personnel and employers, both in private and public, on the California Utilization Review process.

Dr. Randle conducts training sessions to ensure our Claims Examiners are aware of various modalities as well as conducting training for our Clients on topics such as best practices to use for UR. He is always available via a phone call or e-mail to immediately address any questions or concerns.

As AMC's Medical Director, Dr. Randle provides oversight, leadership, and medical expertise to all Managed Care Services provided by AMC. Dr. Randle has served as AMC's Medical Director since 2008. Additional information about Dr. Randle's expertise is further detailed in his resume, which has been included in the noted exhibit.

Physical location and number of employees: The City's Utilization Review program is

conducted out of AMC's Sacramento office located at 10360 Old Placerville Road, Sacramento, California 95827.

As of February 202, AMC has approximately 69 employees.

Org Chart: As requested a company-wide organizational chart with reference to the proposed service office and proposed service team has been provided in the noted exhibit.

Please see Exhibits 1 – Organizational Charts, Exhibit 4 – Teams Resumes, Exhibit 11 – SSAE 18 Reports, Exhibit 12 URAC Reports and Exhibit 13 – AMC UR Audits

B. Service Team Qualifications: Provide a brief summary of the qualifications and experience of each proposed team member, including their length of service with your firm and their resume. Provide an organization chart representing your staff and identify and sub-consultants you plan to utilize to supplement your proposed staff.

AMC's Dedicated, Experienced Medical Management Team: AMC's UR team is a dedicated group of medical case management professionals with tremendous tenure and collectively over 100 years of experience.

Licensed Nurses and Physicians: AMC has only licensed nurses and physicians performing all UR services that go beyond the Claims Examiner. No non-professional staff authorizes treatment or requests referral to Peer Review.

Peer Review: Allied Managed Care utilizes the physician peer review panels of P&S, National Medical Review (NMR), Dane Street, and ClaimsEval; which are all URAC accredited organizations. In addition, physician peer review may be conducted by the Medical Director. The credentialing process for physician peer reviewers is delegated to the respective panels to ensure each physician reviewer meets URAC standards. Also, AMC is not sub-consulting any of the proposed staff.

Listed below are the key members of AMC's UR team.

Mark Denison, Senior Vice President of Operations: Mark oversees the entire customized Bill Review/Utilization Review/Nurse Case Management Program. Mark's role is to monitor all contract compliance with performance standards, audit compliance to individualized *Special Account Instructions;* legal and regulatory compliance; and provide ongoing communication with our Clients. Mark provides unparalleled leadership and direction to all AMC staff. He oversees all operational and administrative components of Allied Managed Care's services, including Medical Bill Review, Utilization Review, and Case Management. He has over 23 years of experience in workers' compensation cost containment, strong multi-jurisdictional managed care knowledge and practical application. His involvement ensures that our Client's performance standards are met and communication is ongoing. Mark will always be available to meet with our Client's staff to discuss issues and performance when requested to do so. Mark is a state board

certified licensed Chiropractor, Certified Disability Evaluator and past Division of Workers Compensation (DWC) appointed Qualified Medical Evaluator (QME). Mark joined the AMC team in 2008.

Lea Morales-Mendez, Director of Client Services: Lea has over 26 years of workers' compensation experience in roles of operations, management as well as Client Services. Lea has received training in Disability Management, Health Insurance Portability and Accountability Act (HIPAA) and Utilization Review Accreditation Commission (URAC). Lea's role is to assist the management team in addressing all issues related to the contract as well as serving as a resource for workers' compensation decisions that may affect our Client. Interact with AMC's management team to resolve all issues that may arise in UR and Bill Review; provide timely communication to the management staff of any critical developments that may affect the product delivery; meet regularly with the management team to assess AMC's performance; discuss business decisions; address concerns; Lea is a resource for our Clients such as the City. Lea joined AMC in 2006.

Alan Randle, M.D., Medical Director: Dr. Randle received his medical degree from the University of San Francisco in 1973. He completed his residency in Seattle, Los Angeles and Cincinnati with a focus on general surgery and occupational medicine. Dr. Randle became certified by the American Board of Preventive Medicine in Occupational Medicine in 1989. Dr. Randle practiced Occupational Medicine while Vice President of RediCare Industrial Medical Clinic through June of 1991. Since that time Dr. Randle has served as Medical Director for several of the largest insurance companies and managed care companies in the country. As Medical Director, Dr. Randle provides oversight, leadership, and medical expertise to all Managed Care Services provided by AMC. Dr. Randle has served as AMC's Medical Director since 2008.

Caroline Iverson, DC, Peer Review Manager: Caroline has 20 years of UR experience with 9 years in workers' compensation UR; eight of which were with public entities. Caroline provides an added level of auditing of the referrals and documents sent from UR nurses to Peer Review physicians and also auditing every completed Peer Review for quality and timeliness. Caroline works closely with the UR Manager and Medical Director to ensure the quality and timeliness of all peer reviews. She coordinates our extensive Utilization Review Quality Management Program and has been a licensed Chiropractor since 1993. Caroline joined AMC in 2008.

Shannon Buelna, LVN, MHA Utilization Review Director: Shannon's workers' compensation UR experience includes 15 years working with public entities to ensure performance of UR services in accordance to the state protocols, guidelines, and regulations. Her initial role was as UR Supervisor and she was promoted to UR Manager in 2014 and Director of Nursing Services in 2022. She continues to be extensively involved in ongoing development of AMC's proprietary software for UR with improved efficiencies, modifications, and adherence to regulatory requirements. She has clinical experience working in a physician's office, skilled nursing, and as director of a 199-bed assisted living facility. Shannon assists in the implementation of Client specific instructions and any new processes which might arise out of DWC revisions. Collaborates with Claims Examiners to ensure proper handling of each referral, understanding of claim status and medical/legal implications, and attention to Client specific instructions.

Licensed Vocational Nurse for over 9 years with licenses in the State of California and the State of Texas. Shannon joined the AMC team in 2008.

Please see Exhibits 1 – Organizational Charts and Exhibit 4 – Team Resumes

C. Services: Describe your utilization review services including standards and guidelines you use to review treatment requests. Describe any unique capabilities or approaches your firm has for reviewing medical treatment requests. Discuss any methods you employ to help clients reduce utilization review costs. Provide an organizational chart, physical location, description of where the work is being conducted, management structure, and number of employees. Discuss your ability to work with TPAs in delivering utilization review services and provide a list of three (3) you currently work with.

Capabilities and Approach: As the City's current UR vendor, AMC provides the City with UR services developed to assess the frequency, duration, intensity and appropriateness of all modalities and procedures common to workers' compensation. This includes concurrent management of hospitalizations and retrospective review of medical treatment not previously reviewed. Reviews are performed by licensed nurses and physicians. The AMC UR program operates under the direction of our Medical Program Director, Dr. Randle. The UR program is compliant with all California-specific regulatory requirements. Reviewers use medical care guidelines such as the Medical Treatment Utilization Schedule (MTUS). Other nationally recognized and publicly available medical necessity criteria sets developed by practicing physicians, such as Work Loss Data Institute/Official Disability Guidelines and Presley Reed/Medical Disability Advisor serve to augment MTUS guidelines. Guideline sets are evaluated annually by the Program Medical Director and updated annually. AMC has created a custom Utilization Review Program for the City of Richmond to address the specific needs called the "Rapid Referral Program". This program expedites the approval process of services and uploads the auxiliary service request to the designated service provider within 1-day a receiving the information.

AMC integrates all cost containment products electronically for maximum efficiency and centralization of data. We realize cost containment programs are a collection point of critical data to measure program costs. AMC can report virtually any data field captured in our system, and provide valuable reports to our Client. This innovative approach provides our Client's managed care program with improved workflow, security/management of documents and increased productivity/turnaround time.

At AMC we have a single-minded UR goal - to help our Client employees return to work by providing the best, most appropriate treatment as quickly as possible and denying those services that are incongruous or unreasonable cost alternatives to nationally recognized treatment standards. By implementing a customized utilization review trigger list, the Claims Examiner can quickly approve a significant amount of first level treatment which allows treatment to be provided quickly as well as saving UR dollars. At AMC, we do not believe everything must be reviewed by the UR unit. We know that our Clients are

not all the same so AMC empowers the claims staff with the safe tools to authorize treatment which falls within the guidelines and is deemed appropriate.

Intake: The request for a UR is received by the Intake Coordinators at AMC. A confirmation email verifying receipt of the referral is sent to the Claims Examiner (and any other personnel designated by the Client) within three hours. Intake staff confirms receipt of all medicals, demographic data, and that the medicals correspond with the referral from the Claims Examiner. The referral documents are sent to the mailroom where they are indexed individually and uploaded into a queue within *AlliedConnect*. The UR Manager assigns the referral to the UR nurse who will open the referral, confirm the data fields, identify if valid/invalid/incomplete/duplicate. The nurse also confirms the receipt date of the request for authorization to ensure AMC is operating under the correct due date. The nurse will indicate the claim designation (prospective, concurrent, retrospective, appeal) and process the review according to the statutory regulations and timelines.

Timeframes: All UR referrals are entered by AMC intake staff into *AlliedConnect* as a prospective review, at which time *AlliedConnect* automatically calculates the fifth business day due date. As part of the nurse's daily triage of the new referrals, the nurses will identify the designation of prospective, concurrent, expedited, appeals, and retrospective. A new due date will be calculated in *AlliedConnect* which corresponds to the service type. If the nurses determine additional information is required, again a new due date will be calculated once the nurse submits the formal request in writing for the additional records. *AlliedConnect* has the ability to calculate the due dates by incorporating weekends and State holidays. The most critical component, though, is to verify the date of receipt which is verified by Intake and again by the nurses. This first critical step will ensure the calculated due dates are correct.

The Supervisor and/or Manager monitor the nurses queues daily to ensure timelines are being met consistently.

The Peer review referrals are submitted to AMC's internal Peer unit no later than business day three, or two business days prior to calendar day fourteen if additional information has been requested. As such, the UR nurses monitor their inventory as well throughout the day to ensure that referrals requiring physician review are sent to the Peer unit promptly and with sufficient time for the physician reviewer to make the decision.

If referred to AMC's internal Peer unit for physician review assignment, the due dates are monitored not only by the UR nurse, but also by the Peer unit via *AlliedConnect*.

Peer reviews are assigned for physician review with the applicable due date clearly marked on the referral. The Peer unit then monitors timeframes by first observing the online "pie chart" widget throughout the day in the *AlliedConnect* Peer module dashboard which reflects the number of reviews due each day, and second by sorting the Peer module's *AlliedConnect* in-box by due date and status to ensure that all referrals are completed by their due date. *AlliedConnect* reports are run by the Peer unit on a daily basis reflecting all pending physician reviews by due date to verify that the reviews are timely. The Peer unit further manages the timeliness of physician reviews by controlling the volume of referrals assigned to each of the Peer review panels so as not to exceed the capacity of any given panel.

Expedited Reviews: Prospective or concurrent decisions related to an expedited review shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. The requesting physician must indicate the need for an expedited review upon submission of the request.

Peer Review Turnaround Times:

- Prospective – 2.8 business days
- Retrospective – 9.6 calendar days
- Appeals – 3.5 business days

Over-prescribing Opioid Medications: Protocols and triggers have been set up with the City's pharmacy benefit manager to help identify trends and assist the City with flagging those providers who may be over-prescribing opioid medications. All new narcotic medication requests and any other identified class of medication can be submitted directly to the pharmacy nurse through an electronic link with the Pharmacy Benefit Management (PBM) or to the Claims Examiner who can forward the request to the AMC nurse who will review for medical appropriateness and certification. If not meeting guideline criteria, the nurse will submit this request to the Peer unit for review. If a formal utilization review has not been received when the narcotic medication is requested, and the request is not within the formulary, the nurse will contact the doctor's office to provide the required documentation for a formal UR review.

AMC has the ability to run UR reports showing what has been requested along with the determination. AMC can identify trends through analysis of this data to identify medications being requested which have been denied or modified and by what prescribing physicians. This data can also be gathered from the PBM. By utilizing both reporting tools, AMC and the City can easily identify the over-prescribers of opioid medications.

A daily report is provided to the PBM that includes all information needed to ensure for the proper dispensing of prescriptions for the Client. The data exported has information that includes but is not limited to demographics for injured workers, claims coding, Examiner information, and claim status information.

Request for Authorization: Whenever an AMC physician reviewer issues a decision to deny a request for authorization (RFA) based on the lack of medical information necessary to make a determination, the claims administrator's file shall document the attempt by the claims administrator or reviewer to obtain the necessary medical information from the physician either by facsimile, mail, or e-mail. If AMC is in receipt of a RFA as part of a UR referral sent by the Claims Examiner after 5 business days from the documented date of receipt (or after 30 days from receipt of the information necessary to perform a retrospective review) and it is therefore determined that the referral has exceeded the timeframe for prospective or concurrent (or retrospective) decisions, the following procedure will be followed:

1. The Claims Examiner will be notified that the UR referral has exceeded the 5 business day timeframe for a prospective determination and 30 days for a retrospective review within the UR Standards.
2. If the Claims Examiner can document that there has been a request for additional information issued on or before the fifth business day after the date of receipt that would appropriately allow an extension of the due date to 14 calendar days, the RFA will be managed in the normal manner as outlined above.
3. If there is no documentation of a prior written request for additional information, the Claims Examiner will have the option of either
    - Authorizing the treatment request and provide appropriate written notification consistent with the UR Standards.
    - Proceeding with the normal UR process for an RFA.

Written decisions approving a request for treatment authorization shall specify the specific medical treatment service approved and the date of the determination.

Written decisions modifying, delaying or denying treatment authorizations will be provided to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney and shall only contain the following information specific to the request:

1. The date on which the DWC Form RFA was first received.
2. The date on which the decision is made (The date of the UR report is the date on which the decision was made unless otherwise specified).
3. A description of the specific course of proposed medical treatment for which authorization was requested.
4. A list of all medical records reviewed.
5. A specific description of the medical treatment service approved, if any.
6. A clear, concise, and appropriate explanation of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity and a description of the relevant medical criteria or guidelines used to reach the decision pursuant to section §9792.8. If a UR decision to modify, deny or delay a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.
7. The Application for Independent Medical Review, DWC Form IMR-1, with all fields completed, except for the signature of the employee and date. The application, set forth at section 9792.10.1, shall include an addressed envelope, which may be postage-paid for mailing to the Administrative Director or his or her designee.
8. A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the UR decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 30 calendar days of receipt of the decision.

If the request for authorization of medical treatment is not approved, or if the request for authorization for medical treatment is approved in part, any dispute shall be resolved in accordance with Labor Code sections 4610.5 and 4610.6. Neither the employee nor the claims administrator shall have any liability for medical treatment furnished without the authorization of the Claims Administrator if the treatment is delayed, modified, or denied by a UR decision unless the UR decision is overturned by independent medical review or the Workers' Compensation Appeals Board under this Article.

A request for independent medical review must be communicated by the employee, the employee's representative, or the employee's attorney by mail, facsimile, or electronic transmission to the Administrative Director, or the Administrative Director's designee, within 30 days of service of the Utilization Review decision. The request must be made on the Application for Independent Medical Review, DWC Form IMR-1, and submitted with a copy of the written decision delaying, denying, or modifying the request for authorization of medical treatment.

If expedited review is requested for a decision eligible for independent medical review, the Application for Independent Medical Review, DWC Form IMR-1, shall include, unless the initial UR decision was made on an expedited basis, a certification from the employee's treating physician indicating that the employee faces an imminent and serious threat to his or her health as described in section 9792.10.1(a)(3).

AMC's Unique Capabilities:

- URAC (Utilization Review Accreditation Commission) Accredited since 2010
- Renowned Medical Director
- Nurse and Physician Determinations – No Determinations completed by non-medical personnel
- Proprietary Software – *AlliedConnect* Database Access Services (AlliedConnect)
- Client Access to *AlliedConnect* Database of Determinations
- Claims Examiner Approval Tracking
- Auto-populates claim information
- Tracking of Request for Authorizations (RFA) from submittal through determination
- Referral status/determination "Look up"
- Peer Review
- Three Medical Specialists Panels – All URAC Accredited
- Quality Assurance Protocols
- Detailed Reporting
- Integrated with BR
- Independent Medical Review (IMR) Process

AMC's Proven Medical Cost Containment Savings

- No duplicate charges
- No charge for reconsiderations within the first thirty (30) days

- Single charge for UR referral regardless of the number of procedures on the request
- Streamlined Claims Examiner approval process
- Direct certified services to Client specific vendors for contracted rates
- Utilize the prior authorization process

Integration of Bill Review and Utilization Review: At AMC we work within our own proprietary platform called, ***AlliedConnect*** database access services (*AlliedConnect*). *AlliedConnect* is a paperless single source solution for UR and integrates the UR and BR systems on the same proprietary platform. In this module, treatment planning or UR parameters can be entered in a highly normalized fashion into the BR system and is associated with a workers' compensation claim. Due to the highly normalized nature of *AlliedConnect* treatment plans, they can be automatically applied by the BR engine during the BR process and require no BR analyst intervention to be applied. This allows UR to communicate directly with BR to ensure the appropriate payment for certified versus modified certified versus non-certified treatment. In other words, this integrated platform ensures, on an automated basis, services approved are the services paid.

AMC has developed a Client Application called, **"*AlliedConnect* Client Module"**, in which the Client can view in real time the status of past, current, and pending reviews. A copy of each determination along with fax confirmations may be printed from the Client Module.

The ***AlliedConnect* Client Module** can also be provided to the Claims Examiner. From within ***AlliedConnect* Client Module**, the Claims Examiner can authorize treatment or submit referrals along with attached medicals to AMC. The Claims Examiner can review past, current or pending referrals in real time. The Claims Examiner can print a determination along with the fax confirmation. This information is also seen by the AMC UR nurses so, they will always know what treatment has been authorized by the Claims Examiner which decreases calls to the Claims Examiner for verification, prevents duplication of services, and thus additional UR fees.

Further benefits include:

- Protect documents against unexpected loss or damage
- Improve workflow by eliminating the need to manually move documents
- Increase security by maintaining better control of documents and regulating document access
- Improve records management and storage
- Portability of documents and information

AMC customizes the workflow to fit the individual needs of the Client. As an example, some Clients have requested adding specific service vendors to the certification letters to assist them in utilizing these providers in which they have special rates or contract relationships. AMC will then send a copy of this certification letter to the specified vendor which will then trigger the referral and assignment process for that service request.

AMC Value Added Services to Reduce Costs:

- AMC's policy related to bundling/unbundling the receipt of the RFA: AMC does not unbundle RFA's. AMC keeps all RFA's that are made by a provider within in one medical report for authorization together, we keep them "bundled". One medical report, which contains more than one treatment request will be reviewed as a whole and the Nurse or Peer Reviewer will make a determination on each treatment request. This is considered one referral with multiple treatment requests. *AMC charges one review fee for multiple treatment requests within one referral.*

- AMC offers a Claims Advice Nurse (CAN-Do) program as value added service to Clients at no additional cost. If the Claims Examiner receives a medical report and requires additional clinical expertise to assist them in understanding the medical condition and treatment requested, the Claims Advise Nurse is available to offer assistance. Many of these discussions result in the Claims Examiner being able to authorize treatment without going through the UR process which expedites the treatment and saves UR fees.

- AMC will identify, monitor and coordinate the medication safety awareness program with the **Pharmacy Benefit Management (PBM) program for narcotics and opioid use.**

  Protocols and triggers set up with the City's pharmacy benefit manager to help identify trends and assist the City with flagging those providers who may be over-prescribing opioid medications. All new narcotic medication requests and any other identified class of medication can be directed to the Claims Examiner by the bill review company who can forward the request to the AMC nurse who will review for medical appropriateness and certification. If the prescribing physician is not meeting guideline criteria, the nurse will submit this request to the Peer unit for review. If a formal utilization review has not been received when the narcotic medication is requested, and the request is not within the formulary, the nurse will contact the doctor's office to provide the required documentation for a formal UR review.

  AMC has the ability to run reports showing what has been requested along with the determination. AMC can identify trends through analysis of this data to identify medications being requested which have been denied or modified and by what prescribing physicians. This data can also be gathered from the PBM. By utilizing both reporting tools, AMC and the City can easily identify the over-prescribers of opioid medications.

  A daily report is provided to the PBM that includes all information needed to ensure for the proper dispensing of prescriptions for our Client. The data exported has information that includes but is not limited to demographics for injured workers, claims coding, Claims Examiner information, and claim status information.

- **AMC's High Employee Retention Rate (Low Turnover)**
  Over the past three (3) years AMC has brought on board a manager to oversee case management for ten (10) nurse case managers. We have also added two (2) utilization review nurses, and additional administrative support - one (1) for Case

Management and two (2) for Utilization Review. These are the benefits of a solid/cohesive team for our Clients:

- Innovative long term consistent managed care program administration
- Detailed knowledge and understanding of our Client's program and needs
- Satisfied, motivated employees who work hard for our Client to provide cost savings and appropriate outcomes and results
- No temporary personnel

❖ **AMC** currently has a **94% upheld rate** with Maximus/IMRs.

❖ **AMC provides documentation required to respond to requests for Independent Medical Review (IMR) at no additional cost to the City**. To minimize the disruption of claims operations, AMC retains all records provided by claim staff. We use a paperless system/document storage that catalogues historical medical records so they only need to be submitted once. Claims staff submitting a second referral on a particular claim only need to submit updated medical records, thus avoiding a large volume of medicals. When a modified or non-certification determination is made, a PDF file of all the medical records reviewed by the Peer Provider, along with the determination will be sent to the Claims Examiner. Therefore, if an IMR is requested the Claims Administrator can request these documents from the UR staff or AMC can ensure they are provided to the Claims Examiner at the time of the determination distribution so they have the necessary information to provide to Maximus and then only needs to include any medicals within that 6 month period which are not part of the Peer packet.

Third Party Administrators: AMC provides UR services through the following TPA's: Acclamation Insurance Management Services (AIMS), TRISTAR, City of Sacramento and other self-insured/self-administered programs.

Physical location and number of employees: AMC provides all of its managed care services out of its office located at 10360 Old Placerville Road, Sacramento, California 95827.

As of February 2022, AMC has approximately 69 employees.

Org Chart: As requested a company-wide organizational chart with reference to the proposed service office and proposed service team has been provided in the noted exhibit.

Please see Exhibits 1 – Organizational Charts and Exhibit 4 – Team Resumes

D. Client References: Provide three (3) references for your firm for which you provide utilization review services including full contact information.

REFERENCE #1 – Utilization Review	
Agency Name County of Los Angeles	
Contact Name Alex Rossi, MBA, ARM, Workers' Compensation Contract Administrator	
Contact Phone Number (213) 738-2154	**Contact Email Address** arossi@ceo.lacounty.gov
Brief Description of Scope of Services All Managed Care Services / Client since 2006	

REFERENCE #2 – Utilization Review	
Agency Name City of Sacramento	
Contact Name Patrick Flaherty, Risk Manager	
Contact Phone Number (916) 808-8587	**Contact Email Address** pflaherty@cityofsacramento.org
Brief Description of Scope of Services All Managed Care / Client since 2018	

REFERENCE #3 – Utilization Review	
Agency Name Central San Joaquin Valley Risk Management Authority	
Contact Name Kevin Werner, City of Ripon, City Administrator	
Contact Phone Number (209) 599-2108	**Contact Email Address** kwerner@cityofripon.org
Brief Description of Scope of Services All Managed Care Services / Client since 2012	

REFERENCE #4 – Utilization Review
Agency Name Schools Insurance Group (SIG)
Contact Name Jaxine Anderson, Return to Work Coordinator

REFERENCE #4 – Utilization Review	
Contact Phone Number (530) 823-9582 x205	**Contact Email Address** Jaxinea@sigauburn.com
Brief Description of Scope of Services Workers' Compensation Claims Administration and Managed Care / Client since 2013	

City of Richmond - Insurance Requirements - Type 2: Professional Services

In all instances where CONTRACTOR or its representatives will provide professional services *(architects, engineers, construction management, counselors, medical professionals, hospitals, clinics, attorneys, consultants, accountants, etc.)* to the City of Richmond (City), the City requires the following MINIMUM insurance requirements and limits.

CONTRACTOR shall procure and maintain for the duration of the contract, agreement, or other order for work, services or supplies, insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder and the results of that work by the CONTRACTOR, its agents, representatives, employees or subcontractors. **Maintenance of proper insurance coverage is a material element of the contract. Failure to maintain or renew coverage or to provide evidence of renewal may be treated by the City as a material breach of contract.**

CONTRACTOR agrees that in the event of loss due to any of the perils for which it has agreed to provide Commercial General Liability insurance, CONTRACTOR shall look solely to its insurance for recovery. CONTRACTOR hereby grants to CITY, on behalf of any insurer providing Commercial General Liability insurance to either CONTRACTOR or CITY with respect to the services of CONSULTANT herein, a waiver of any right to subrogation which any such insurer of said CONTRACTOR may acquire against the CITY by virtue of the payment of any loss under such insurance.

Original, signed certificates and original, separate policy endorsements, naming the City as an additional insured for general liability coverage, as well as a waiver of subrogation for Workers' Compensation insurance, shall be received and approved by the City **before any work may begin**. However, failure to do so shall not operate as a waiver of these insurance requirements.

City reserves the right to modify or require additional coverages for specific risk exposures depending on scope of CONTRACTORS work.

Minimum coverage is detailed below. The policy limits of coverage shall be made available to the full limits of the policy. The minimum limits stated herein shall not serve to reduce the policy limits of coverage of CONTRACTOR.

Minimum Scope of Insurance – the following forms shall be provided and coverage shall be at least as broad as the following:

1. Insurance Services Office Commercial General Liability coverage (ISO Occurrence Form CG 0001), and including coverage for bodily and personal injury, property damage, and products and completed operations (if applicable).
2. Insurance Services Office Automobile Liability coverage (ISO Form CA 0001, Code 1, Any Auto).
3. Original and Separate Additional Insured Endorsement for General Liability (ISO Form CG 20 10 11/85 or its equivalent) with primary and non-contributory language.
4. Workers' Compensation Insurance as required by the State of California including Employer's Liability coverage.
5. Original and Separate Waiver of Subrogation for Workers' Compensation insurance.
6. Professional Liability or Errors & Omissions Liability Insurance appropriate to the CONTRACTOR's profession (if required.)

Required Coverage	Minimum Limits
Workers' Compensation and Employers' Liability	Statutory limits as required by the State of California including $1 million Employers' Liability per accident, per employee for bodily injury or disease. If CONTRACTOR is self-insured, provide a certificate of Permission to Self-Insure, signed by the California Department of Industrial Relations and Self-Insurance. If contractor is a sole proprietor (has no employees) than contractor must sign "Contractor Release of Liability" found at: ***http://www.ci.richmond.ca.us/index.aspx?nid=61***.
General Liability *(primary and excess limits combined)*	**$2,000,000** per occurrence for bodily injury, personal injury and property damage. If the policy includes a general aggregate, either the general aggregate shall apply separately to this project, service or location or the **minimum required aggregate limit shall be twice the per occurrence limit ($4 million aggregate limit).** Policy shall be endorsed to name the City of Richmond as an additional insured per the conditions detailed below.

City of Richmond - Insurance Requirements - Type 2: Professional Services

Automobile Liability	**$1,000,000** per occurrence for bodily injury and property damage.
Professional Liability or Errors & Omissions Liability – *Required for all professionals including architects, engineers, consultants, construction management, counselors, medical professionals, hospitals, clinics, attorneys and accountants, & other consultants as may be required by the City.*	**PROJECT COST** / **REQUIRED LIMIT** $0 - $1 million / $1 million p/o $1 million - $5 million / $2 million p/o Over $5 million / $5 million p/o

Required Policy Conditions	
Additional Insured Endorsement	Applicable to General Liability coverage. The City of Richmond, its officers, officials, employees, agents and volunteers are to be named as additional insureds for all liability arising out of the operations by or on behalf of the named insured including bodily injury, deaths and property damage or destruction arising in any respect directly or indirectly in the performance of this contract. ***ISO form CG 20 10 (11/85) or its equivalent is required. If the Contractor is supplying their product or providing a service then the endorsement must not exclude products and completed operations coverage. If it does, then CG 20 37 (10/01) is also required. SAMPLE Endorsements can be found at http://www.ci.richmond.ca.us/index.aspx?nid=61.***
Primary and Noncontributory	The contractor's insurance coverage must be primary coverage as it pertains to the City, its officers, officials, employees, agents and volunteers. Any insurance or self insurance maintained by the City is wholly separate from the insurance of the contractor and in no way relieves the contractor from its responsibility to provide insurance.
Waiver of Subrogation Endorsement Form	Contractor's insurer will provide a Waiver of Subrogation in favor of the City for Workers' Compensation Insurance during the life of this contract. SAMPLE Endorsements can be found at ***http://www.ci.richmond.ca.us/index.aspx?nid=61***.
Deductibles and Self-Insured Retentions	Any deductible or self-insured retention must be declared to and approved by the City. At the option of the City either the insurer shall reduce or eliminate such deductibles or self-insured retention as respects the City or the CONTRACTOR shall procure a financial guarantee in an amount equal to the deductible or self-insured retention guaranteeing payment of losses and related investigations, claims administration and defense expenses. Contractor is responsible for satisfaction of the deductible and/or self-insured retention for each loss.
A. M. Best Rating	A:VII or Better. If the A.M. Best Rating falls below the required rating, CONTRACTOR must replace coverage immediately and provide notice to City.

Umbrella/Excess Liability Policies

If an Umbrella or Excess Liability Policy is used to meet the liability limits, coverage shall be as broad as specified for underlying coverage's and cover those insured in the underlying policies.

City of Richmond - Insurance Requirements - Type 2: Professional Services

Claims-Made Policies

If any insurance policy is written on a claims-made form: 1) the retroactive date must be shown, and must be before the date of the contract or the beginning of contract work. 2) Insurance must be maintained and evidence of insurance must be provided for at least five (5) years after completion of the contract of work. 3) If coverage is canceled or non-renewed, and not replaced with another claims-made policy form with a retroactive date prior to the contract effective date, the Contractor must purchase an extended period coverage for a minimum of five (5) years after completion of contract work.

Subcontractors

CONTRACTOR shall include all subcontractors as insured under its policies or shall furnish to the City for review and approval, separate certificates and endorsements for each subcontractor. All coverage for subcontractors shall be subject to all of the requirements stated herein.

CONTRACTOR agrees to defend and indemnify the City of Richmond for any damage resulting to it from failure of either CONTRACTOR or any subcontractor to take out or maintain the required insurance policies. The fact that insurance is obtained by CONTRACTOR, and/or CONTRACTOR's subcontractors, will not be deemed to release or diminish the liability of CONTRACTOR, including, without limitation, liability under the indemnity provisions of this contract. Damages recoverable by CITY from CONTRACTOR or any third party will not be limited by the amount of the required insurance coverage.

Verification of Coverage

All original certificates and endorsements shall be received and approved by the City ***before work may begin***. The City of Richmond reserves the right to require complete, certified copies of all required insurance policies including endorsements affecting the coverage at any time.

Original insurance certificates and required policy endorsements shall be mailed or delivered to the Designated Project Manager for the City of Richmond.

Insurance certificates and endorsements may be faxed to the Designated Project Manger. However, CONTRACTOR must mail the original certificates and endorsements to Designated Project Manager once faxed.

Continuous Coverage

CONTRACTOR shall maintain the required insurance for the life of the contract. Should the CONTRACTOR cease to have insurance as required during this time, all work by the CONTRACTOR pursuant to this agreement shall cease until insurance acceptable to the City is provided. In the event that CONTRACTOR fails to comply with the City's insurance requirements, the City may take such action as it deems necessary to protect the City's interests. Such action may include but is not limited to termination of the contract, withholding of payments, or other actions as the City deems appropriate.

If services or the scope of work extend beyond the expiration dates of the required insurance policies initially approved by the City, CONTRACTOR must provide updated certificates and endorsements indicating that the required coverage, terms and conditions are still in place. **Renewal certificates and updated endorsements shall be mailed to the Designated Project Manager.**

Cancellation

CONTRACTOR shall ensure that coverage shall not be cancelled, reduced or otherwise materially changed except after thirty (30) days' prior written notice has been given to the City.

Reporting Requirements

Any failure to comply with reporting or other provisions of the policies including breaches of warranties shall not affect coverage provided to the City, its officers, officials, employees or volunteers.

Consistent with Public Policy

The insuring provisions, insofar as they may be judged to be against public policy shall be void and unenforceable only to the minimum extent necessary so that the remaining terms and provisions herein may be consistent with public policy and thus enforceable.