CONSULTANT SERVICES AGREEMENT BETWEEN THE CITY OF SUNNYVALE AND ACCLAMATION INSURANCE MANAGEMENT SERVICES, INC. FOR WORKERS' COMPENSATION CLAIMS ADMINISTRATION SERVICES

THIS AGREEMENT dated _____ is by and between the CITY OF SUNNYVALE, a municipal corporation ("CITY"), and Acclamation Insurance Management Services, Inc. (AIMS), a California corporation ("CONSULTANT").

WHEREAS, CITY is in need of specialized services in relation to workers' compensation claims administration services; and

WHEREAS, CONSULTANT possesses the skill and expertise to provide the required services;

NOW, THEREFORE, THE PARTIES ENTER INTO THIS AGREEMENT.

1. Contract Documents

The complete Contract consists of the following documents: Request for Proposal No. F15-57, consisting of a Notice Inviting Proposals, Instructions to Proposers, Specifications, Terms and Conditions, CONSULTANTS's Proposal relating to Claims Administration Services (Exhibit "B"), and Cost Proposal (Exhibit "C"). These documents are all incorporated by reference. The documents comprising the complete contract are collectively referred to as the Contract Documents.

Any and all obligations of the CITY and the CONSULTANT are fully set forth and described therein.

All of the above documents are intended to cooperate so that any work called for in one and not mentioned in the other or vice versa is to be executed the same as if mentioned in all documents.

2. Time for Performance

The term of this Agreement shall be from July 1, 2015 to June 30, 2018, unless otherwise terminated. One-year extensions to the agreement may be granted by the City Manager upon a showing of good cause.

3. Duties of CITY

CITY shall supply any documents or information available to City required by CONSULTANT for performance of its duties. Any materials provided shall be returned to CITY upon completion of the work.

4. Compensation

CITY agrees to pay CONSULTANT at the rates shown in Exhibit "C". Total compensation shall not exceed Nine Hundred Twenty-Four Thousand Three Hundred Sixteen and No/100 Dollars ($924,316). CONSULTANT shall submit invoices to CITY no more frequently than monthly for services provided to date. Payment shall be made within thirty (30) days upon receipt of an accurate, itemized invoice by CITY's Accounts Payable Unit.

5. Ownership of Documents

CITY shall have full and complete access to CONSULTANT's working papers, drawings and other documents during progress of the work. All documents of any description prepared by CONSULTANT shall become the property of the CITY at the completion of the project and upon payment in full to the CONSULTANT. CONSULTANT may retain a copy of all materials produced pursuant to this Agreement.

6. Conflict of Interest

CONSULTANT shall avoid all conflicts of interest, or appearance of conflict, in performing the services and agrees to immediately notify CITY of any facts that may give rise to a conflict of interest. CONSULTANT is aware of the prohibition that no officer of CITY shall have any interest, direct or indirect, in this Agreement or in the proceeds thereof. During the term of this Agreement CONSULTANT shall not accept employment or an obligation which is inconsistent or incompatible with CONSULTANT'S obligations under this Agreement.

7. Confidential Information

CONSULTANT shall maintain in confidence and at no time use, except to the extent required to perform its obligations hereunder, any and all proprietary or confidential information of CITY of which CONSULTANT may become aware in the performance of its services.

8. Compliance with Laws

(a) CONSULTANT shall not discriminate against, or engage in the harassment of, any City employee or volunteer or any employee of CONSULTANT or applicant for employment because of an individual's race, religion, color, sex, gender identity, sexual orientation (including heterosexuality, homosexuality and bisexuality), ethnic or national origin, ancestry, citizenship status, uniformed service member status, marital status, family relationship, pregnancy, age, cancer or HIV/AIDS-related medical condition, genetic characteristics, and physical or mental disability (whether perceived or actual). This prohibition shall apply to all of CONSULTANT's employment practices and to all of CONSULTANT's activities as a provider of services to the City.

(b) CONSULTANT shall comply with all federal, state and city laws, statutes, ordinances, rules and regulations and the orders and decrees of any courts or administrative bodies or tribunals in any manner affecting the performance of the Agreement.

9. Independent Contractor

CONSULTANT is acting as an independent contractor in furnishing the services or materials and performing the work required by this Agreement and is not an agent, servant or employee of CITY. Nothing in this Agreement shall be interpreted or construed as creating or establishing the relationship of employer and employee between CITY and CONSULTANT. CONSULTANT is responsible for paying all required state and federal taxes.

10. Indemnity

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

11. Insurance

CONSULTANT shall take out and maintain during the life of this Agreement policies of insurance as specified in Exhibit "A" attached and incorporated by reference, and shall provide all certificates or endorsements as specified in Exhibit "A."

12. CITY Representative

Anthony Giles, as the City Manager's authorized representative, shall represent CITY in all matters pertaining to the services to be rendered under this Agreement. All requirements of CITY pertaining to the services and materials to be rendered under this Agreement shall be coordinated through the CITY representative.

13. CONSULTANT Representative

Lynn Cavalcanti shall represent CONSULTANT in all matters pertaining to the services and materials to be rendered under this Agreement; all requirements of CONSULTANT pertaining to the services or materials to be rendered under this Agreement shall be coordinated through the CONSULTANT representative.

14. Notices

All notices required by this Agreement, other than invoices for payment which shall be sent directly to Accounts Payable, shall be in writing, and shall be personally delivered, sent by first class with postage prepaid, or sent by commercial courier, addressed as follows:

To CITY: Anthony Giles, Human Resources Manager
Human Resources Department
CITY OF SUNNYVALE
P. O. Box 3707
Sunnyvale, CA 94088-3707

To CONSULTANT: Lynn Cavalcanti, Sr. Vice President of Operations
Acclamation Insurance Management Services, Inc.
10445 Old Placerville Road
Sacramento, CA 95827

Nothing in this provision shall be construed to prohibit communication by more expedient means, such as by telephone or facsimile transmission, to accomplish timely communication. However, to constitute effective notice, written confirmation of a telephone conversation or an original of a facsimile transmission must be sent by first class mail or commercial carrier, or hand delivered. Each party may change the address by written notice in accordance with this paragraph. Notices delivered personally shall be deemed communicated as of actual receipt; mailed notices shall be deemed communicated as of two days after mailing, unless such date is a date on which there is no mail service. In that event communication is deemed to occur on the next mail service day.

15. Assignment

Neither party shall assign or sublet any portion of this Agreement without the prior written consent of the other party.

16. Termination

If CONSULTANT defaults in the performance of this Agreement, or materially breaches any of its provisions, CITY at its option may terminate this Agreement by giving written notice to CONSULTANT. If CITY fails to pay CONSULTANT, CONSULTANT at its option may terminate this Agreement if the failure is not remedied by CITY within thirty (30) after written notification of failure to pay.

Without limitation to such rights or remedies as CITY shall otherwise have by law, CITY also shall have the right to terminate this Agreement for any reason upon ten (10) days' written notice to CONSULTANT. In the event of such termination, CONSULTANT shall be compensated in proportion to the percentage of services performed or materials furnished (in relation to the total which would have been performed or furnished) through the date of receipt of notification from CITY to terminate. CONSULTANT shall present CITY with any work product completed at that point in time.

17. Entire Agreement; Amendment

This writing constitutes the entire agreement between the parties relating to the services to be performed or materials to be furnished hereunder. No modification of this Agreement shall be effective unless and until such modification is evidenced by writing signed by all parties.

18. Miscellaneous

Time shall be of the essence in this Agreement. Failure on the part of either party to enforce any provision of this Agreement shall not be construed as a waiver of the right to compel enforcement of such provision or any other provision. This Agreement shall be governed and construed in accordance with the laws of the State of California.

IN WITNESS WHEREOF, the parties have executed this Agreement.

ATTEST:

By_____
City Clerk

APPROVED AS TO FORM:

By_____
City Attorney

CITY OF SUNNYVALE ("CITY")

By_____
City Manager

ACCLAMATION INSURANCE MANAGEMENT SERVICES, INC. (CONSULTANT)

By_____

_____
Name and Title

By _____

_____
Name and Title

EXHIBIT A
INSURANCE REQUIREMENTS

Consultant shall procure and maintain for the duration of the contract insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work by the Consultant, his agents, representatives, or employees.

Minimum Scope and Limits of Insurance

Consultant shall maintain limits no less than:

1. **Commercial General Liability**: $1,000,000 per occurrence and $2,000,000 aggregate for bodily injury, personal injury and property damage. ISO Occurrence Form CG 0001 or equivalent is required.

2. **Automobile Liability**: $1,000,000 per accident for bodily injury and property damage. ISO Form CA 0001 or equivalent is required.

3. **Workers' Compensation** Statutory Limits and **Employer's Liability**: $1,000,000 per accident for bodily injury or disease.

4. **Errors and Omissions** Liability Insurance appropriate to the Consultant's Profession: $1,000,000 per occurrence.

Deductibles and Self-Insured Retentions

Any deductibles or self-insured retentions must be declared and approved by the City of Sunnyvale. The consultant shall guarantee payment of any losses and related investigations, claim administration and defense expenses within the deductible or self-insured retention.

Other Insurance Provisions

The **general liability** policy shall contain, or be endorsed to contain, the following provisions:

1. The City of Sunnyvale, its officials, employees, agents and volunteers are to be covered as additional insureds with respects to liability arising out of activities performed by or on behalf of the Consultant; products and completed operations of the Consultant; premises owned, occupied or used by the Consultant; or automobiles owned, leased, hired or borrowed by the Consultant. The coverage shall contain no special limitations on the scope of protection afforded to the City of Sunnyvale, its officers, employees, agents or volunteers.

2. For any claims related to this project, the Consultant's insurance shall be primary. Any insurance or self-insurance maintained by the City of Sunnyvale, its officers, officials, employees, agents and volunteers shall be excess of the Consultant's insurance and shall not contribute with it.

3. Any failure to comply with reporting or other provisions of the policies including breaches of warranties shall not affect coverage provided to the City of Sunnyvale, its officers, officials, employees, agents or volunteers.

4. The Consultant's insurance shall apply separately to each insured against whom claim is made or suit is brought, except with respect to the limits of the insurer's liability.

5. Each insurance policy required by this clause shall be endorsed to state that coverage shall not be suspended, voided, cancelled by either party, reduced in coverage or in limits except after thirty (30) days' prior written notice by certified mail, return receipt requested, has been given to the City of Sunnyvale.

Acceptability of Insurers

Insurance is to be placed with insurers with a current A.M. Best's rating of not less than A:VII, unless otherwise acceptable to the City of Sunnyvale.

Verification of Coverage

Consultant shall furnish the City of Sunnyvale with original a Certificate of Insurance effecting the coverage required. The certificates are to be signed by a person authorized by that insurer to bind coverage on its behalf. All certificates are to be received and approved by the City of Sunnyvale prior to commencement of work.

ACCLAMATION INSURANCE MANAGEMENT SERVICES

To help the City of Sunnyvale (City) review Acclamation Insurance Management Services (AIMS) proposal, our responses are laid out to mirror D. Scope of Work and E. Proposal Content of the City's Request for Proposals (RFP) NO. F15-57 for Workers' Compensation Claims Administration Services. The RFP text has been extracted in verbatim and is in black font and the AIMS responses are in a blue font. Also, we capitalize the word, "Client" in our documentation to signify the integral role and respect we have for these relationships.

D. Scope of Work

Introduction

The City of Sunnyvale (City) is seeking competitive proposals from qualified third-party administrators (TPA) for administration of the City's self-insured workers' compensation claims including bill review, utilization review, and nurse case management services (collectively called "managed care services"). The City seeks service providers with experience in public entity workers' compensation self-insurance who promote a proactive approach to manage and administer benefits in accordance with California State laws and statutes with a focus on quality care.

It is the City's intent to enter into a three (3) year contract with one or more experienced firms to provide claims administration and managed care services for all new and existing self-funded workers' compensation claims beginning July 1, 2015. The contract may be renewed for additional one-year periods if service and rates remain acceptable to the City. The City may elect to award separate contracts for claims administration, bill review, utilization review, and nurse case management services or may elect to award one contract for all services to one firm, whichever is determined to be in the City's best interest. Interested bidders are welcome to respond to this entire Request for Proposal (RFP), may respond only to claims administration, or may respond to one or more of the managed care services. Each main service category listed in the Scope of Work will be evaluated and awarded independently. In the event that one or more firms are awarded ancillary support service contract(s), the selected TPA must have the capability to work with these firms.

This RFP requires interested firms submit specific information in accordance with Proposal Submittal Requirements and Cost Proposal. Bidders may expand on the information requested and/or provide other related information. However, it is important that bidders follow the directions, proposal format, and comply with all directions contained in the RFP to ensure that the proposal is considered.

The contract will require the selected TPA operate under the general direction of the City and consult with City personnel in developing effective procedures and practices to successfully administer the City's self-insurance program for workers' compensation. It will also require the claims administrator meet all legal requirements of the State of California Department of Industrial Relations, Division of Workers' Compensation including the California Labor Code, rules and regulations of self-insurance, and the California Administrative Code. In addition, the claims administrator must comply with conditions of the City's excess contracts, the City's performance standards, and the City's labor contract provisions. The City currently does not use a medical provider network.

Minimum Qualifications

Each proposal received by the City will be evaluated to determine if the proposing firm meets the following minimum qualifications. Proposals that do not meet these minimum qualifications will not advance to the Selection Committee for further evaluation.

AIMS Executive team has reviewed the Minimum Qualifications and addressed each one in the noted Request for Proposal response. We are confident this information will illustrate our expertise and knowledge of the Workers' Compensation Claims Administration Services being requested by the City of Sunnyvale.

A. The firm, its principals, and its lead claims examiners servicing the City shall have at least five (5) years' experience in California as a third party workers' compensation administrator or providers of ancillary services such as bill or utilization review for public entities.

AIMS has over 40 years' experience claims administration experience for public entities. AMC has over 20 years' experience in bill review and over 10 years' experience conducting utilization review for public entities. The City's assigned AIMS Examiners will have at least 5 years' experience. Please see our response to Section E. Proposal Content, Claims Administration, Question A.

B. Proposed claims service office is located in close proximity to San Francisco Bay Area or the Sacramento Valley area and provides assurance of reasonable staffing at that location for the term of the contract.

AIMS proposes providing the City with claims administration services from our office located at 10445 Old Placerville Road, Sacramento, California 95827. Managing the account from our Sacramento office, affords "value added" components of the organization such as our dedicated Client Services Division, Internal Audit Unit, Information Technology Group, and our Executive Management Team.

C. Present a certificate of insurance evidencing the Proposer meets the City's insurance requirements in accordance with the insurance exhibit outlined in this RFP. The certificate of insurance must be included in your RFP response.

Please see Exhibit 1 – Certificate of Insurance

Claims Administration

A. Firm's Qualifications: Describe the firm and provide a statement of qualifications for performing the requested scope of work as outlined in Scope of Work - 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.

AIM'S QUALIFICATIONS

Acclamation Insurance Management Services, Incorporated (AIMS), a wholly owned subsidiary organization of **LJRH Holdings, Inc. (LJRH)**, 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 medical cost containment for public and private entities, including those that are self-insured and self-administered, and insurance companies throughout the United States and Hawaii.

Originally founded in 1973 as Leonard J. Russo Insurance Services, Inc., this privately owned organization is incorporated in the State of California and has been administering property/liability and workers' compensation claims continuously for over forty (40) years. In January 1990, the current corporate name, AIMS, was assumed to better reflect the diverse nature of our product offering. LJRH provides all corporate services to its subsidiaries, AIMS and Allied Managed Care (AMC). The services provided by LJRH are: 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 the subsidiary companies. Its corporate headquarters are in Sacramento, California. A company-wide organizational chart is provided as an exhibit to illustrate the firm's structure and to highlight the proposed service office and team.

- 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 your workers' compensation program.

- As a privately held company, we bring a transparent approach to establishing TPA programs; a unique skill set, and a different perspective focused on issues that are more relevant to Clients based in California versus national and publicly held third party administrators.

To provide the City with an experienced team that meets all of its needs, AIMS proposes providing the City with claims administration services from our office located at 10445 Old

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To provide the City with an experienced team that meets all of its needs, AIMS proposes providing the City with claims administration services from our office located at 10445 Old Placerville Road, Sacramento, California 95827. Managing the account from our Sacramento office, affords "value added" components of the organization such as our dedicated Client Services Division, Internal Audit Unit, Information Technology Group, and our Executive Management Team.

All AIMS offices are certified by the State of California to administer workers' compensation claims by Self Insurance Plans. As a multi-line claims administrator, AIMS goes beyond ordinary third party administration services and provides customized, flexible loss management programs and services designed to generate lower claims costs and better outcomes. As noted in our response to question G. regarding Client References, **AIMS** currently has over ***100 Clients throughout California*** that range in size from small utility districts to a JPA consisting of 53 cities to the large City of Los Angeles sworn Fire personnel claims and all sizes in between. We have been providing claims administration services for two-thirds of these Clients for greater than 10 years. We currently administer over 12,000 open claims for our California-based Clients of which approximately 80% are public entities and 20% are private entities.

We understand the public sector environment and know how to achieve the best possible results for both the injured employee and the City. We currently have over one hundred (100) Clients throughout California that range in size from small utility districts to the large City of Los Angeles Fire Safety Officers' workers' compensation program, as well as numerous standalone cities throughout California and a JPA consisting of 53 cities. We have been providing claims administration services for two-thirds of these customers for greater than ten (10) years. Our technical personnel are well versed and trained in those special areas of workers' compensation that relate to public employees such as the California Education Code, safety officers/firefighters (4850), multiple salary continuation scenarios, PERS/CALPERS and other public employee retirement programs.

We effectively handle applications of salary continuation benefits, medical management

programs which include Return-to-Work protocols, Medical Bill review, Utilization Review, Nurse Case Management, Early Intervention by an in-house nursing staff, and customized Medical Provider Networks to name a few.

Please see Exhibit 1 – Corporate Organization Charts, Exhibit 3 – AIMS Sample Claim System Reports, and Exhibit 4 - Sample Legislative Digest

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.

Based on the current open claim counts provided by the City in this RFP, it is estimated that one primary Senior Claim Examiners will spend their time dedicated to the City's files. A Future Medical Examiner will be assigned to handle the future medical only claims City files. Both Examiners will manage claims up to the maximum caseload according to the requirements of CSAC-EIA claims administration guidelines amended Oct. 4, 2013 which states "Each claims examiner assigned to the Member should handle a targeted caseload of 150 but not to exceed 165 claims. In situations where caseloads include future medical and medical only claims, these claims shall be counted as 2:1 in the caseload limit." Of course, all supporting staff (i.e., Manager, Supervisor, Claims Assistant, Clerical, etc.) will spend the necessary corresponding time to support the efforts of the Examiner (s) assigned to the City's program.

The AIMS general staffing model is one (1) Manager to a maximum of six (6) Supervisors; one (1) Supervisor to a maximum of six (6) Examiners; two (2) Claim Assistants for every six (6) Examiners and one and one-half (1.5) Clerical for every six (6) Examiners. AIMS generally allocates Claim Assistants and Clerical time based on the claims volume and work demands for a particular Client. Our Examiners generally average between 125 to 150 indemnity claims but Client requirements always prevail. Our average indemnity claim inventory includes future medical claims and a blend of high to low severity claims.

AIMS Supervisors do not generally carry a caseload, enabling them to provide technical oversight of the individual claims and of the employers' workers' compensation programs, ensuring quality client service, as well as compliance with regulatory and client-specific program performance standards. All technical personnel assigned will be certified by the Department of Self-Insurance Plans to administer self-insured workers' compensation

claims, 4850 experience and possess the necessary certification as mandated by Insurance Code Section 11761.

As a matter of practice, AIMS designates key personnel to an account based on Client requirements and strives to maintain consistency of the assigned team on each of our valued Clients. If claims frequency and customer 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.

AIMS will staff the City's account with a blend of current experienced personnel and new hires. AIMS will make every effort to hire the personnel that is desirable to the City. Before any offers are made, candidates may be interviewed by the City personnel to reinforce our thoughts on who would best fit the program. AIMS staffing is predicated on the information in this RFP, and subject to the limitations set forth by the City.

All technical personnel assigned will be certified by the Department of Self-Insurance Plans to administer self-insured workers' compensation claims, 4850 experience and possess the necessary certification as mandated by Insurance Code Section 11761. The Senior Claims Examiner will have public entity experience which will include administering 4850 benefits.

Organizational charts displaying the structure of LJRH Corporation and the lines of authority within AIMS have been included. The key people are highlighted in the following and resumes are included in the Exhibits section of our proposal.

Our Corporate Team, which includes AIMS primary project team members to the City include Lynn Cavalcanti, Tricia Baker, and Kim Silas, who will be involved throughout the life of the City's program. The other members of our corporate team will work with the City on as needed basis.

Dominic Russo, President & CEO: Dominic has served as President of AIMS since 1994 and as President & CEO of both AIMS and AMC since 2011. Under his leadership, AIMS/AMC has consistently met its Corporate Strategy: *"As a Client-driven organization, deliver measurable financial results to our Clients through our intelligent use of sophisticated technology and 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."*

Prior to Dominic's position as President & CEO, he served in various positions of management from Supervisor to Vice President in Southern California, Northern California, and Hawaii and as a Claims Examiner from 1980 through 1987.

Lynn Cavalcanti, Sr. Vice President Operations: Lynn has over twenty years workers'

compensation claims experience all of which has been accumulated in the public entity sector. She has a Master of Arts as well as Juris Doctorate degrees. Her role is to serve customers for AIMS by establishing critical service, operations, and productivity criteria; benchmarking leading-edge practices; exploiting marketing channels; leading our commitment to quality service; evaluating service results, and representing the company to our customers (making periodic visits; exploring specific needs, and resolving problems). Lynn has been with AIMS since 2010.

Patricia Baker - Assistant Vice President, Operations: Tricia has over 15 years of workers' compensation claims experience. She has a Bachelor of Science in Business Administration and holds her Self-Insured Plans certification. 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 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.

Kim Silas, Workers' Compensation Claims Manager and Claims Supervisor: 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 Claim Manager since 2011. The AIMS transition team would be led by Kim who is experienced and thoroughly familiar with the assumption and implementation of new Clients and would be responsible for quality assurance and overseeing the physical file triage and development of individual proactive action plans for all open claims. Kim also has over 10 years managing safety personnel claims including 4850 benefits. Kim joined AIMS in 2011.

Rendell R. Johnson, Vice President Information Technology: Ren has held various positions in the information technology industry over the last 19 years, 16 years in leadership positions, including the last 10 years as Information Technology Director in the

workers' compensation industry and recent promotion to Vice President Information Technology. Ren has been making strategic technology decisions and providing state of the art solutions for pre-IPO (initial public offering), government, and healthcare, workers' compensation, and enterprise environments. He has studied in Business Administration with training and certifications in networking, security, and Microsoft technologies. Ren oversees program implementation from an Information Technology (IT) perspective and is always available to AIMS customers as needed. Ren joined the AIMS team in 2010.

Diane P. Wratten, Director of Data Delivery: Diane has over 20 years workers' compensation claims experience. Her primary role is to effectively coordinate conversions and maintain computer systems, work with Branch Offices to complete monthly, quarterly, annual reporting requirements and special reports. Diane is a state-certified self-insurance administrator, she is also certified in Crystal Report Design, California Basic Educational Skills Test (CBEST) Certification and Workers' Compensation Claims Professional (WCCP). Diane has been with AIMS since 1998.

Provided below are descriptions of the functions of key positions and selection qualifications.

Role of the Senior Examiner: Their essential function is to provide proactive claims management of the individual claims they handle and to promote the overall success of the claims program. This equates to delivering at all times quality service, communications, and results for the employers and their injured employees. In order to achieve this, Senior Claims Examiners must be experienced, with manageable caseloads, and have adequate clerical and administrative support provided to them in order that they may fulfill their roles.

Role of the Future Medical Only Examiner: Their essential function is to monitor open Future Medical claims by establishing and maintaining a 90-day or 60-day review diary to include documenting adequacy of reserves and reports or reimbursement requests to the Excess Carrier; follow up with medical providers and Clients for current status to ensure the timely delivery of all species of benefits as well as appropriate State mandated form letters. The Future Medical Only Examiner attends outside meetings/presentation as needed; balances and reconciles Medical and Indemnity payments every 90 days; when provision of benefits changes; and at closure of the claim and other duties as assigned.

Minimum Experience Required:

- 1-2 years previous experience as a Claim Assistant
- Has received or will receive workers' compensation training as specified by Ins. Code 11761

Role of the Claims Assistant: Our Assistant Examiners are technical claims people who have completed or are in the process of completing all of their Insurance Educational Association courses in workers' compensation and, in many instances, who have passed

the Self-Insurance Plans Administrators Exam. They are our next generation of Claims Examiners through our in-house training program. The essential role of the Claims Assistant is to provide full administrative support to their Examiners and handle medical only claims. This supporting role allows the Examiners to be proactive case managers and not get bogged down in clerical/administrative tasks.

Please see Exhibit 2 – Corporate Organization Charts and Exhibit 5 – AIMS Team Resumes and Job Descriptions

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.

The Claims Supervisors consistently manage the Claims Examiner's caseloads to ensure caseload levels are managed based on the Client specific requirements. AIMS will develop customized *Special Account Instructions* for the City. These standards will outline the customized approach to the City's claims administration program which includes specific procedures and protocols as outlined in the Request for Proposal No. 856 and as required by the City. We identify specific claims handling instructions and interface specifications that meet the goals of the new Client. The result of this meeting is the *Special Account Instructions*, which is a formal document that outlines the claims administration and handling processes and requirements.

Implementation meeting discussion topics include but are not limited to:

- Discuss employees and the current/preferred staffing plan
- Confirm banking procedures, exchange financial information
- Determine claims systems specifics, etc.
- Determine vendor panel
- Discuss work flow
- Establish goals for program
- Review and determine reports required, to whom and the frequency to be provided
- Determine schedule for annual evaluation, Client training and claim reviews
- Any other issues that are critical to a smooth implementation

Performing the Scope of Work

AIMS takes a proactive approach on every claim to establish and maintain open and positive lines of communication with the injured employees. We will assist injured City employees through the entire workers' compensation process, respond to their questions

and concerns and provide timely appropriate benefits in accordance with regulations. Every new claim reported is entered into our claims management system within 24 hours and will be triaged by the Supervisor to identify all key technical issues, nature and scope of the injury, provide instructions to the appropriate Claims Examiner. Contact will be made with the injured employee, the City, and the medical provider within 24 hours. Immediately following our 24 hour contact, AIMS will send all City injured employees a customized "care" letter that expresses concern, acknowledges receipt of the claim, and advises the injured employee of the names, toll-free phone number and extensions, of their Claims Examiner and claim Assistant. We continue to communicate with the injured employee on a regular basis and bi-weekly while off work.

The Claims Examiner will conduct regular follow-up throughout the life of the claim file, which includes providing information, guidance and assistance regarding permanent disability ratings, Qualified Medical Exams and the settlement process. Contact is made verbally and followed-up in writing to appropriately document the activity in claim file. After the contacts have been made, our Examiner will complete a reserve worksheet based upon the probable ultimate cost (derived from available information) and present the suggested reserve to the Supervisor for approval within seven days of the assignment. As a part of our standard initial investigative practices, all indemnity claims are indexed for prior history. This process is repeated in six month cycles for as long as the claim file remains active.

As an integral part of our "Client-centric" approach, the assistance provided to injured employees focuses on quality of life and returning to the pre-injury status as quickly as possible. It may involve meeting with the employee's family in the case of a catastrophic injury or having a nurse case manager counseling the family members who may be undergoing undue stress due to the injury. We strive to address all concerns of the injured employee and family with our pro-active approach to management of their claim, and we are a resource to helping them through traumatic times associated with their accident.

The following Time Performance Standards are part of AIMS audit process to help us maintain our goal of keeping claims on track for prompt resolution.

ACTIVITY	TIMEFRAME
Claim set up in Computer	Within one (1) working day of date knowledge
Initial Claimant Contact	Within one (1) working day of date of knowledge
Subsequent Claimant Contact	As needed – or a maximum of every thirty (30) days
Initial Client Contact	Within one (1) working day of date of knowledge
Subsequent Claimant Contact	As needed – or a maximum of every thirty (30) days

ACTIVITY	TIMEFRAME
Initial Medical Provider Contact	Within one (1) working day of date of knowledge
Initial Payment of Disability	Within fourteen (14) days of first day off disability
Investigation	Within three (3) days of knowledge of condition requiring investigation
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	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 medical bills	Within thirty (30) days of receipt of bill
Payment of electronic bills	Within fifteen (15) days of electronic receipt
Contested medical bills	Notice to provider within twenty (20) calendar days that bill is contested, denied or incomplete
Payment of Awards, C&R's, stipulations	Within fourteen (14) calendar days of receipt
Litigation	Referral to defense council no more than twenty-five (25) 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

ACTIVITY	TIMEFRAME
Subrogation	Notification/Contact with negligent third party within thirty (30) days of determination of existence of subrogation
Balancing of Claim File	Maximum of every ninety (90) days
Excess Reporting/Reimbursement	Initial reporting—within thirty (30) 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
Correspondence	Incoming Mail—date stamped within one(1) working day of receipt
Return Correspondence	Written answer completed and returned within five (5) working days of receipt
Supplemental Job Displacement Vouchers (Potential Notice)	Via Certified Mail 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
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
QME Exams	To Be Determined
Supervisory File Reviews	At a maximum of every ninety (90) days
Home Office Reserve Notification	Within one (1) day of any reserve change over $100,000
Return Checks/Voids	Within five (5) working days of receipt

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.

Reserves: AIMS practice is to assess and evaluate the nature and extent of each claim, and establish claim reserves for compensation, medical, vocational rehabilitation, and legal expenses. After the contacts have been made, the examiner will complete a reserve worksheet based upon the probable ultimate cost (derived from available information) and present the suggested reserve to the supervisor for approval within seven (7) days of the assignment. Reserve estimates are not determined by formulas, but, rather, are based on current information in the file including medical reports, current and anticipated medical treatment, and periods of disability, disputed or litigated issues, and additional areas of investigation and on the laws of the particular jurisdiction. Understating the reserves, overstating the reserves, or "step-reserving" are not the policy of AIMS and are to be avoided at all times. Medical reserves are based on current information in the file and anticipated future medical treatment. After a claim has been settled with a future medical award, future medical reserves are calculated based on a three-year average and the injured worker's life expectancy.

Litigation: AIMS has formal Litigation Procedures that we incorporate in our handling of litigated claims which will be in full cooperation with attorneys designated by the City. Our Litigation Procedures involve preparing the necessary documentation for transmitting the claim to defense counsel with instructions.

The Examiner will direct the litigation and jointly serve, with defense counsel and the City, in terms of how the case progresses. 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. We also prepare and report the progress on the claim to our Client, and together all parties are prepared in a timely fashion to deliver the most favorable disposition of the litigation possible. We recognize the importance of timely notification of scheduled appearances and commit to providing adequate notice to the handling defense attorney firm within five days from initial receipt of Notice of Hearing.

All medical information received from applicant or his/her attorney will be forwarded within five days from the date of initial receipt. All benefits paid to the applicant will be summarized and a Balance Sheet completed and delivered to the defense counsel at least ten days, if not sooner, prior to the Mandatory Settlement Conference. Subsequent hearings or proceedings mandated by the Workers' Compensation Appeals Board (WCAB) will also have the most recent summary of the benefits paid, along with a copy of the current Balance Sheet.

The (WC) Claims Manager is also responsible for reviewing and enforcing compliance with the State of California Labor Code.

Investigation: Insurance fraud in California exceeds $15 billion dollars per year, driving up the cost of claims for California employers. AIMS provides strong anti-fraud and

investigative services via our Special Investigations Unit (SIU) for our Clients. AIMS works with a strategic partner with extensive anti-fraud and investigative services experience to perform oversight of investigation firms used by our Clients to ensure the quality and cost effectiveness of investigation efforts, using a state-of-the-art Investigation Management module as well as conducting regular fraud identification and Examiner plan of action training. Our strategic partner works with our staff to ensure thorough investigations are completed and cases are brought to a conclusion, including prosecution by the appropriate authorities. There is no additional cost to our Clients for this oversight program.

AIMS Fraud Policy & Procedures: AIMS protects the assets of our Clients by actively pursuing suspected fraud. All applicable statutes are followed regarding reporting and investigation of suspected fraudulent acts or behavior.

AIMS Claims Examiners are experts at identifying and pursuing fraudulent claims activity for investigative services. Our staff has received extensive training on fraud procedures and reporting to the Fraud Bureau. In addition to identifying potential fraudulent claims, the claims Examiner will develop a progressive action plan to guide and monitor further fraud investigation, coordinate efforts with the local District Attorney's office and keep key Client personnel apprised of all updates. We have online access for reporting claims to the Fraud Unit. All potential fraud cases are given to the Supervisors for screening. Before final submission, SIU Managers review all fraud referrals. AIMS logs all claims where a fraud investigation referral is made. We have reported many cases to the Bureau, of which a significant number have resulted in conviction, sentencing, and restitution for our Clients.

Outside Investigation Steps:

1. All claims requiring an investigation are 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) are 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 will have the prior approval of the Client.
4. The Claims Examiner or his/her designee(s) monitors 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

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

Online System Reporting: AIMS provides an online Risk Management Information System (RMIS) that allows our Clients access to all Claims Examiner notes, financials, medical reports as permitted by law, and Claims Examiner action plans. The following information is a sample of what AIMS Clients can view within the claims system - Claims Summary, Claims Examiner Notes, Detailed Payment Information, Detail Transaction, Managed Care (UR and Fee Schedule), Billing Information and Prior TPA Information. Copies of all correspondence such as medical legal reports, depositions, denial letters, attorney correspondence, etc. are available upon request. This information is also available by viewing the claim correspondence/documents in the claim system.

With AIMS reporting program, we offer our Clients the independence to manage their own reporting needs or use a team approach by utilizing the AIMS Data Delivery Services (DDS) department. AIMS Clients can produce comprehensive analyses of their claims programs, dashboard reports, batch reports, graphs, standard PDF based reports and Excel based reports.

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, and Word. AIMS Clients can produce comprehensive analysis of their claims programs, dashboard reports. All these capabilities provide AIMS Clients with the knowledge to fully understand and manage their loss portfolio.

AIMS promotes the use of our online claim system to our Clients by not only providing initial Claim system training sessions at the time of implementation but ongoing regularly scheduled training sessions as needed are scheduled on an ongoing basis. The dates and times of the upcoming training sessions can be found on the first page of the claim system. AIMS provides unlimited on-line training for our Clients, which includes training on new features.

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

To keep up-to-date 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 charge and has been a valuable primer in keeping our Clients aware of the potential rules and regulations that affect workers' compensation in the State.

Quality Assurance: AIMS Internal Audit Unit, headed by the Vice President of Workers' Compensation, conducts audits against our *AIM 4 Excellence* established procedures as well as the Client's *Special Account 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 as needed. 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 Claims Supervisors carry independent diaries for this purpose. Audit scores are incorporated into the performance evaluations that are 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.

Rules and Regulation Updates: 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 charge and has been a valuable primer in keeping our Clients aware of the potential rules and regulations that affect workers' compensation in the State.

Focused 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.

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.

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."

Medicare and Medicaid Required Reporting: 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 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 vendor / ancillary services to ensure performance-levels and continued value-add to our Clients.

Audit Results: 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 has consistently and successfully passed audits conducted by Division of Workers' Compensation's Audit Unit, Self-Insurance Plans, California State Association of Counties/ Excess Insurance Authority (CSAC-EIA), other excess carriers, and Client specific auditors. This demonstrates AIMS qualification to administer claims in full accordance of applicable rules, regulations, laws and the City's requested scope of work. State audit results are public information and verifiable on the website for the California Department of Industrial Relations, Office of Self Insurance Plans. AIMS administers all claims for workers' compensation benefits in accordance with the requirements of the workers' compensation laws of the State of California.

Rapid Referral Program: 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.

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.

AIMS takes a **"Loss Portfolio Management®"** approach to managing claims programs. 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.

A true partnership between our Client and the claims 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 will involve partnering with the City to assess specific needs and then develop a customized claims management program designed to combat claim exposures and costs for the City.

The key elements of a program for the City would entail:

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

Maximum number of indemnity files: We are proposing a "dedicated" examiner so the inventory will vary with the volume of claims received versus those closed but not to exceed the California State Association of Counties (CSAC) cap of 175. The average indemnity caseload for a senior Claims Examiner is 150. If no specific caseload is specified, we target 150 indemnity claims per Claims Examiner with a 2:1 claim assistant to Claims Examiner ratio. 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.

2. If volume does not warrant, Claims Examiners are assigned on a designated basis.

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.

D. Ancillary Services: Identify any company-owned and affiliated ancillary services to include, but not limited to, bill review, utilization review, and nurse case management. 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 focuses exclusively on two facets of the workers' compensation process: claims administration (since 1973) and providing medical cost containment services (bill review, utilization review, and nurse case management) through our sister company, AMC (since 1995). More details on AMC's managed care services are provided in the proposal sections: Bill Review, Utilization Review, and Nurse Case Management.

AMC is a wholly owned subsidiary of LJR Holdings, Inc. (LJRH), the holding company for both AMC and AIMS. AMC was established in 1995 with one central goal – to provide professional medical cost containment that results in lower total program costs to our Clients.

AMC has nearly 20 years of experience managing sophisticated programs like the City of Sunnyvale's. AIMS/AMC can offer the City, innovative managed care programs for cost effective management at the onset of all claims. These programs include Medical Bill Review, Utilization Review, Nurse Case Management, PPO networks, Early Return to Work programs, Paperless Solutions for Bill Review processing and Utilization Review treatment planning and a Director of Client Services (single point of contact) to develop and maintain specific strategies to ensure proactive program management and compliance with the State's and City's requirements. These services include State reporting, Workers' Compensation Appeals Board (WCAB) appearances if needed, audit preparation, and report generation to maximize all areas of cost containment to bring real savings back to the City as well as to allow the City the ability to track and measure their medical management services costs and savings.

The AMC team is supported by an extensive management, technical and support staff located in multiple offices located throughout California and Hawaii. AMC has Best Practice Performance Standards and supports those standards through an extensive quality assurance program, Utilization Review Accreditation Commission (URAC) accreditation, broad employee knowledge base, and our proprietary state-of-the-art computer system, *AlliedConnect database access services* (AlliedConnect).

By offering our Client's a one-stop solution it has shown itself to be a most effective way of managing our Client's programs for several reasons:

- Flexibility, control and cost effectiveness
- Utilize premiere service providers
- Give our clients the power to hand pick vendors that they have had historical success with
- Promote competition among service providers which helps to continuously drive and sustain competitive services and pricing

- Eliminates the potential for conflict of interest issues (There are no hidden fees or revenue sharing agreements in place. AIMS only earns revenue for AIMS services)

AMC has gone through an extensive process to research and interview numerous ancillary service providers and networks in order to offer a comprehensive ancillary service provider network panel that gives our Clients the best possible service and value. We have established business processes with ancillary networks for Diagnostics, Durable Medical Equipment, Physical Medicine, Transportation, Translation, Return-to-Work, Home Health Services, Pharmacy Benefit Management and life care plans. 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 service providers or networks our Client prefers.

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.

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 David Corporation, NavRisk System, which is an Internet-based claims management system built on Microsoft.Net technology, designed for anytime, anywhere access.

Our electronic claim management system provides a wide array of information in which the City can immediately evaluate the current condition of its customized program. Access to this information will allow the City to effectively manage their workers' compensation program and to confidently make high impact risk management decisions. Our web-based system will provide the City extensive on-line capabilities for reporting claims, customized report generation and immediate real time access to key information from any location. AIMS is able to provide unique direct access to relevant information in countless layout's and in numerous formats via the Internet.

Enhanced Value:

- Web-based entry of (Employers' First Report of Industrial Injury or Illness)

- 1099 reporting to the IRS
- Self-Insurers Annual Report generation
- OSHA reports
- Electronic interface with the Index Bureau and WCIS
- Production of all required reports and data exports (real time and viewed archived reports)
- EDI compliant
- Access all performance metrics (dashboard view)

Types of data available electronically to the City: In addition to extensive reporting, the following information is a sample of what AIMS clients can view within the claims system: Claims Summary, Examiner Notes, Detailed Payment Information, Detail Transaction, Managed Care (UR, Fee Schedule), Billing Information and Prior TPA Information. Copies of all correspondence such as medical legal reports, depositions, denial letters, attorney correspondence, etc. are available upon request. This information is also available by viewing the claim correspondence/documents in the claim system.

Client customizations: Over the years our system has been modified extensively to meet the specific customized requirements of our customers. Our system is an extremely powerful data management claims system for both standard and ad hoc report generation. An extensive list of standard reports is available through our program. Selection parameters, such as dates, locations, type of claim, and status, allow the user to create custom reports.

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 into the following categories. This allows us to more effectively track benefit payment, reserve and incurred data. The system tracks lost time, temporary modified duty and temporary partial disability.

- Temporary Disability
- Permanent Disability
- Labor Code 4850
- Death Benefits
- Medical
- Legal Expenses
- Other Expenses (includes investigations)

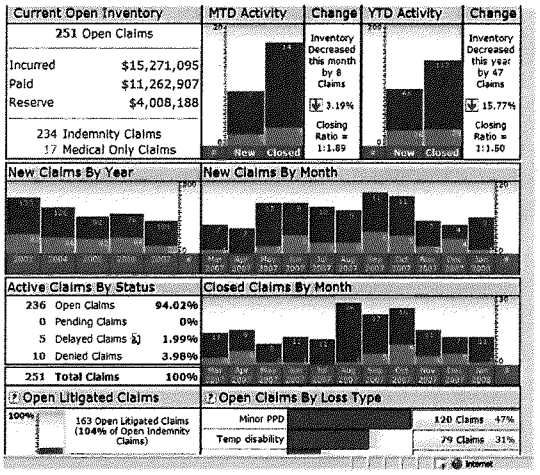
- Vocational Rehabilitation Benefits
- Maintenance Benefit
- "Capped" Vendor Costs
- Miscellaneous Program Costs (Training, etc.)

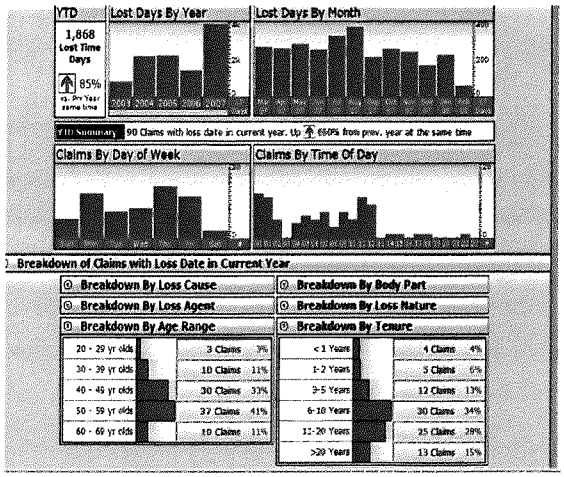
Data Integrity and Security: The system is upgraded on a continuous basis. Our claims information system utilizes state-of-the-art technology including access security, nightly back-ups with off-site storage, an Uninterrupted Power Source to ensure continued use in the event of a power shortage, and a formal business interruption plan.

The City will have direct access to our claims management system through the Internet. 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.

AIMS Client Metrics Dashboard – Customized for the City

Our Internet based metrics dashboard system will allow the City's Risk Manager to closely manage the City's workers' compensation programs from an overall perspective. We will work with the City to define exactly what management information is most valuable. **We will program the City's specific website and create a real time risk management portal that will allow the risk management staff to review as frequently as they like, on their own time.** This web based tool arms the City with the power of information and allows the risk manager to run their programs more effectively and to make high impact decisions with a greater degree of confidence. This technology is included in our claims administration services and there are no additional costs or expenses to the City.





Screen shots of AIMS Client Metrics Dashboard, our on-line real time risk management information system

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, 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.

AIMS' Technology team consists of a total of 12 employees in total. The IT department includes a highly technical team of Helpdesk/Desktop Support, Data Delivery Services, and software development staff. The Data Delivery Services Department can provide the City with all the technical support, training, and reporting needs necessary for the RMIS software. The primary contact is Diane Wratten, Director of Data Delivery Services. AIMS will be responsive and assist with technical support required by the City at no additional cost.

An extensive list of standard reports is available through our program. Selection parameters, such as dates, locations, type of claim, and status, allow the user to create custom reports. Reports can be provided at any interval as set forth by the client through our customized reporting schedule. There is no additional charge for standard reports. Should the City require a highly customized report that is not readily available through the standard report library, a special request is submitted to the AIMS Data Delivery Department. The costs of these special request reports are dependent on the necessary system programming required by David Corporation and are handled on a "pass-through" basis from David Corporation.

Many AIMS clients request monthly, quarterly and annual reports. Some of the more useful reports utilized by our public sector clients to effectively manage their program from both a micro and a macro level are listed below:

- Claims Cost Detail Reports
- Claims Summary by Year Report
- Claims Cost Summary
- Financial Reconciliation Ledger
- Management Summary Report
- A monthly listing of open claims by department/division
- A monthly listing of open claims alphabetically by claimant
- Summaries of all open and closed claims
- Listing of future medical only claims
- Special reports upon request, such as injury analysis by cause, occupation, body part, department, etc. are available on the dashboard.

- Reserve analysis reports, which include initial reserve, reserve at closing and total amount paid.
- Quarterly penalty reports and reimbursements

As part of the quarterly meetings, we can present customized "Stewardship" reports. This program analysis presents hard data to benchmark results and determine strategies to improve and optimize the program we create specifically for you. We are also available to assist in preparation and presentation of these reports to your governing Board. Reports can be provided at any interval as set forth by the client through our customized reporting schedule and can be exported into other applications such as PDF or Excel. We can customize the safety management reports (specific data to be captured) that are important to the client.

AIMS can provides its clients with very comprehensive annual reports, which provide both a global and a detailed analysis of all claim, risk management (including safety), and financial program evaluations. This is done in colored graphic/chart form for easy reading by management and includes our analysis of any deficiencies in the program and very specific recommendations for program improvement. The reports are department/cost-center specific and, as requested by our clients, more frequent special-focus reports can be done if the need arises. AIMS coordinates with our customers to provide a full array of stewardship and benchmarking reports. This process promotes our philosophy of service and a team approach for our customers.

Excess policy information is maintained for each client in the claim system. When an individual claim's reserves reach or exceed the reporting level for that policy period, the claim system displays a reminder on the screen. Any claim that threatens to pierce the excess layer shall be reported immediately to the carrier but in no case more than five (5) days from recognition of the exposure.

Training: AIMS promotes the use of the claim system to our Clients by not only providing initial Claim system training sessions at the time of implementation but ongoing regularly scheduled training sessions as needed are scheduled on an ongoing basis. The dates and times of the next training session can be found on the first page of the claim system. AIMS provides unlimited on-line training for our Clients, which includes training on new features.

Please see Exhibit 3 – Sample Claim System 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 successfully completes its SSAE 16 audit annually. The Statement of Standards for Attestation Engagements No. 16 (SSAE 16) effectively supersedes SAS 70 on or after June 15, 2011. The SSAE 16 audits effectively report on the relevant internal controls established by AIMS, especially the financial and confidential data controls, in performing

our services to our Clients. First, controls are established that describe the service organization's description of security controls at a specific point in time. Second, the audit includes the service organization's description of controls and also includes detailed testing results of the service organization's controls over a minimum six-month period.

In today's global economy, service organizations or service providers must demonstrate that they have adequate security controls and safeguards when they host or process data belonging to their Clients. We undergo SSAE 16 audits annually to ensure controls are effective. We are serious about our business and the security of your information.

Please see Exhibit 6 – SSAE 16 and URAC Accreditation Reports

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.

AIMS currently has over ***100 Clients throughout California*** that range in size from small utility districts, a JPA consisting of 53 cities to the large City of Los Angeles sworn Fire personnel claims and all sizes in between. We have been providing claims administration services for two-thirds of these Clients for greater than 10 years. We currently administer over 12,000 open claims for our California-based Clients of which approximately 80% are public entities and 20% are private entities.

AIMS five (5) Client references are provided below:

CLIENT NAME	ADDRESS	CONTACT NAME	APPROXIMATE # OF INDEMNITY CLAIMS ANNUALLY
Salinas Valley Memorial Hospital	450 East Romie Lane, Salinas, CA 93901 / 831-759-1985	Jill Peralta Cuellar	Between 36-80 annually
Judicial Branch Workers Compensation Program	455 Golden Gate Avenue, San Francisco, CA 94102 / 415-865-4290	Linda Cox	401
City of Los Angeles	700 E. Temple Street, Room 210, Los Angeles, CA 90012 / 213-473-3378	Dawn Alvarado	Do not have access to City of Los Angeles system data.

CLIENT NAME	ADDRESS	CONTACT NAME	APPROXIMATE # OF INDEMNITY CLAIMS ANNUALLY
Central San Joaquin Valley Risk Management Association	53 City Group – C/O City of Fowler, 128 South Fifth Street, Fowler, CA 93625 / 916-290-4619	David Elias	310
City of Huntington Beach	2000 Main Street, Huntington Beach, California 92648 / 714-536-5290	Patti Williams	90

EXHIBIT 1

Certificate of Insurance

DESCRIPTIONS (Continued from Page 1)

insureds coverage is primary and non-contributory. Any insurance or self-insurance maintained by the City of Sunnyvale, its officers, officials, employees, agents and volunteers shall be excess of the insured's surance and shall not contribute with it. Any failure to comply with reporting or other provisions of the policies including breaches of warranties shall not affect coverage provided to the City of Sunnyvale, its officers, officials, employees, agents or volunteers. The insured's insurance shall apply separately to each insured against whom claim is made or suit is brought, except with respect to the limits of the insurer's liability. Each insurance policy shall not be suspended, voided, cancelled by either party, reduced in coverage or in limits except after thirty (30) days' prior written notice by certified main, return receipt requested, has been given to the City of Sunnyvale.

Claims Adjusting and Claims Management Services
Thirty day notice of cancellation will be provided to the certificate holder but 10 days for non-payment of premium. Named insured includes: Acclamation Insurance Management Services, Inc.; Allied Managed Care, Inc.; LJR Holdings, Inc.; LJR Properties, LLC
EMPLOYEE DISHONESTY / CRIME COVERAGE: Executive Risk Indemnity, Inc. #82344565 EFF: 1/1/15 EXP: 1/1/16
DISHONESTY LIMIT: $2,000,000 $35,000 DEDUCTIBLE

Revised April 13, 2015

Cost Proposal
For
City of Sunnyvale, California

6. A cost proposal which shall be submitted in a separate, sealed envelope. Proposed costs for each component should be as specified below.

   A. Claims Administration: Flat annual fee for service

   B. Bill Review: Flat fee per bill

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

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

Claims Administration Cost Proposal

Acclamation Insurance Management Services, Inc. (AIMS) proposes a "flat annual fee" for the Claims Management Services which includes the handling of all current open claims, new indemnity claims and new medical only claims (including first aid claims) during the life of the contract. A flat annual fee provides a fixed and predictable budget item for the City of Sunnyvale (CITY) and 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 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, Corporate overhead and a reasonable profit are added to the total operating costs to determine a reasonable claims administration fee for the program.

The pricing is based upon the open claims at takeover (158 lost time indemnity claims, 116 open future medical (maintenance) indemnity claims, and 19 medical only claims) as set forth in the subject RFP and any Addendum(s) or additional information provided. Future medical indemnity claims may be counted on a 2:1 basis or, in other words, 2 future medical indemnity claims equals 1 lost time indemnity claim.

The fees set-forth below are based on AIMS recommended staffing for the CITY program to handling all the claims identified in the subject RFP. The staffing includes a dedicated Senior Examiner and a designated Future Medical Examiner. Of course, the necessary Management, Supervision and support staff will be provided. The staffing will adhere to the requirements of the subject RFP. AIMS will adhere to the desired caseloads of 150 indemnity claim files per Examiner. Of course, the necessary corporate management, Claims management, IT management, Clerical staff and other support staff will be assigned to the CITY'S program.

AIMS proposes the "flat annual fee" for the Workers' Compensation Third Party Claims Administration Services, with a 3% subsequent year cost of living increase.

As distinguished from other service providers, AIMS and Allied Managed Care, Inc. (AMC) price their services on a stand-alone basis. In other words, AIMS prices the claims administration services without regard to whether AMC is being used and vice-versa. The fees are the same whether the services are bundled together or unbundled. This provides for a transparency for our Clients to clearly understand what they are paying for.

However, should AIMS and/or AMC be selected for consideration to be the service provider for the CITY'S program then AIMS and AMC are open to negotiating a "best and final" fee arrangement that is mutually beneficial to all parties on either a bundled or unbundled basis.

As indicated above, the fees proposed cover claims administration for all new and existing claims set forth in this RFP. This fee is premised on, and in reliance on, the claim volumes as set forth in the RFP or related information provided (158 open Indemnity, 116 open future medical, and 19 medical only claims). Should AIMS receive more claims than anticipated from the current claim administrator at the time of transfer and/or there is a 5% increase/decrease during the initial transfer or during any period of the contract due to significant change in the number of employees, and/or as a result of a catastrophic event, then both AIMS and the CITY will negotiate, in good faith, a reasonable fee increase/decrease fee adjustment based on any revised required staffing.

Year One (7/1/2015-6/30/2016)	**$ 295,000.00***
Year Two (7/1/201-6/30/2016)	**$ 303,850.00****
Year Three (7/1/2016-6/30/2017	**$ 312,966.00****

**Not included is a one time, direct pass through, fee for data conversion costs billed separately. Fee will not exceed $12,500.00. Actual fee may be lower.*

*** Annual cost of living adjustment of 3%*

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 including, but not limited to, the following services:

• All Claims Management Functions (currently open & new claims)	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
• 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**
• Data Conversion/Implementation Fee	$12,500.00***

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

****Denotes a one time, direct pass through, fee for data conversion costs. Fee will not exceed $12,500.00. Actual fee may be lower.*

Customization of reports: Most ad-hoc report request 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 client before proceeding. All specialized report fees are on a "pass-through" basis.

Risk Management Information System Access: Unlimited users included in Flat Annual Fee.

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. 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;
- Cost for employing experts for the preparation of maps, professional photographs, accounting, chemical or physical analysis, diagrams;
- Cost 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;
- Cost 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 us 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.