

NOTICE OF SPECIAL MEETING

In accordance with §38-431.02 of the Arizona Revised Statutes of the State of Arizona, notice is hereby given to the Employee Benefit Trust Board and to the general public that the Mayor and Trustees of the Employee Benefit Trust Board will hold an Employee Benefits Trust Board Meeting at 4:00 PM., on Wednesday, January 10, 2024. The meeting will take place at the City Council Chambers, located at 1090 E. Union Street, San Luis, Arizona, 85349.

In accordance with the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973, the City of San Luis does not discriminate on the basis of disability in the admission of or access to, or treatment of employment in its programs, activities, or services. For information regarding rights and provisions of the ADA or Section 504, or to request reasonable accommodations for participation in City programs, activities or services contact: ADA/Section 504 Coordinator, City of San Luis Human Resources Department, 1090 East Union Street, San Luis, Arizona 85349; (928) 341-8579.

Notice is hereby given that pursuant to A.R.S. §1-602.A.9, subject to certain specified statutory exceptions, parents have a right to consent before the State or any of its political subdivisions make a video or audio recording of a minor child. Meetings of the City Council are audio and/or video recorded, and, as a result, proceedings in which children are present may be subject to such recording. Parents in order to exercise their rights may either file written consent with the City Clerk to such recording, or take personal action to ensure that their child or children are not present when a recording may be made. If a child is present at the time a recording is made, the City will assume that the rights afforded parents pursuant to A.R.S. §1-602.A.9 been waived.

THIS NOTICE IS APPROVED BY:

/s/ Maria Barajas, Human Resources Benefits Coordinator

AVISO DE JUNTA ESPECIAL

De acuerdo con los Estatutos del Estado de Arizona A.R.S. §38-431.02, se le informa a los miembros de la Junta Fiduciaria de Beneficios para Empleados y al público en general que el Presidente y la Mesa Directiva de Fondo de Beneficios Medicos de San Luis, Arizona, tendrán una Junta Especial a las 4:00 PM, el día Miercoles, 10 de Enero, 2024. La junta se llevará a cabo en la Sala del Cabildo, ubicada en el 1090 E. Union Street, San Luis, Arizona, 85349.

De acuerdo con el Acta de Americanos con discapacidades y la Sección 504 del Acta de Rehabilitación del 1973, la Ciudad de San Luis no discrimina por causa de discapacidad la admisión y acceso a sus programas, actividades, servicios o en el trato en cuanto a empleo. Para mas información referente a derechos y provisiones del Acta de Americanos con discapacidades o Sección 504, o para solicitar adaptaciones que sean razonables para la participación en programas, actividades o servicios de la ciudad, contactar al: Coordinador del Acta de Americanos con discapacidades/Sección 504, Departamento de Recursos Humanos de la Ciudad de San Luis, 1090 Este Calle Unión, San Luis, Arizona, 85349; (928) 341-8579.

Por medio de este aviso y de acuerdo con los Estatutos Revisados del Estado de Arizona, sujeto a ciertas excepciones reglamentarias, los padres de familia tienen el derecho de dar o no dar el consentimiento antes que el Estado o alguna subdivision política grabe a un menor de edad, ya sea en audio o video. Las juntas del Concilio se graban en audio y/o video y como resultado, el hecho de que haya menores presentes puede ser sujeto a que sean grabados. Para que los padres de familia puedan ejercer sus derechos pueden solicitar por escrito con la Secretaria de la Ciudad a tal grabación, o tomar acción personal para asegurarse que su hijo/hija menor no esté presente cuando la grabación se lleve a cabo. Si un menor de edad esta presente en el momento de la grabación, la Ciudad asumirá que los padres de familia están cediendo los derechos sobre una posible grabación de acuerdo con el Estatuto Revisado del Estado de Arizona §1-602.A.9.

ESTE AVISO ES APROBADO POR:

/f/ Maria Barajas, Coordinadora de Beneficios de Recursos Humanos

AGENDA
Special Meeting
City of San Luis Employee Benefit Trust
Council Chambers – City Hall
1090 E Union Street
San Luis, AZ 85349
Wednesday, January 10, 2024
4:00 PM

NOTE: Some members of the Board of Trustees of the City of San Luis Employee Benefit Trust may attend the meeting telephonically. If authorized by majority vote of the Board of Trustees, an executive session will be held immediately following the vote in accordance with A.R.S. §38-431.03(A) and the meeting will be temporarily recessed while the Board retires to executive session which will not be open to the public.

AVISO: Algunos miembros de la Junta de Fiduciaria de Beneficios para Empleados de la Ciudad de San Luis pueden asistir a la reunión por teléfono. Si se autoriza por mayoría de votos de la Junta de Síndicos, se llevará a cabo una sesión ejecutiva inmediatamente después de la votación de acuerdo con A.R.S. §38-431.03(A) y la reunión tendrá un receso temporal mientras la Junta se retira a la sesión ejecutiva que no estará abierta al público.

- 1. CALL TO ORDER/ROLL CALL**
- 2. CONSENT AGENDA**
- 2. A. MINUTES OF:**
-Special meeting held on October 24, 2023
- 3. DISCUSSION AND POSSIBLE ACTION ITEMS:**
- 3. A.** Discussion and possible action on any and all matters regarding a contract with CBIZ Benefits & Insurance Services, Inc. for employee benefits broker and consultant services.
(Kay Marion Macuil, City Attorney)
- 4. ADJOURNMENT**

Special Employee Benefit Trust Board Meeting

2. A.

Meeting Date: 01/10/2024

Summary

MINUTES OF:

-Special meeting held on October 24, 2023

Attachments

MINUTES MEETING 10.24.2023

MINUTES
Special Meeting
City of San Luis Employee Benefit Trust
Council Chambers - City Hall
1090 E. Union Street
San Luis, AZ 85349
October 24, 2023
11:00 a.m.

1. CALL TO ORDER/ROLL CALL

Chairman Tadeo Azael De La Hoya called the meeting to order at approximately 11:05 a.m.

PRESENT: Tadeo Azael De La Hoya, Chairman
Emma Torres, Vice-Chairwoman
Maria Gonzalez, Board Member
Gustavo McGrew, Board Member
Maria Sabori, Secretary

OTHERS PRESENT: Nieves Riedel, Mayor
Kay Macuil, City Attorney
Sonia Cornelio, City Clerk
Adela Cortez, Director of Human Resources
Antonio Maldonado, Video Production Specialist
Mary Barajas, Human Resources Coordinator
Monica Castro, Director of Finance
Olivia Jenkins, Operations Coordinator
Ruben Lopez, I.T. Technician

2. CONSENT AGENDA

2. A. MINUTES OF
-Special meeting held on October 17, 2023

MOTION: Chairman Tadeo Azael De La Hoya/Secretary Maria Sabori to approve the Consent Agenda as presented. Motion passed unanimously.

The vote was as follows:

Chairman Tadeo Azael De La Hoya	Aye
Vice-Chairwoman Emma Torres	Aye
Board Member Maria Gonzalez	Aye
Board Member Gustavo McGrew	Aye
Maria Sabori, Secretary	Aye

3. DISCUSSION AND POSSIBLE ACTION ITEM:

3. A. Discussion and possible action on any and all matters regarding the acceptance and award of the Brokerage/Consulting services contract for the City of San Luis Employee Benefit Trust. (Adela Cortez, Human Resources Director)

Ms. Adela Cortez, Director of Human Resources, explained that staff was instructed to conduct a survey and request proposals; an official Request For Qualifications was put together and a total of four (4) responses were received. The four (4) proposals were evaluated, reviewed and interviews were conducted on the four (4) vendors. She added that attached to the agenda item is an evaluation chart that outlines the results of the process. Staff is requesting approval for accepting and awarding a contract for Professional Services to the vendor as selected by the Board.

Secretary Maria Sabori asked what the standard formal process is for the award.

Ms. Cortez responded that the process is a selection similar to a recruitment where the candidate with the highest score would be the selection or recommended choice.

Vice Chairwoman Emma Torres commented that last week the Board saw the results and had the opportunity to view what each vendor is offering. She understood that staff would present a recommendation to the Board.

Ms. Jenny Torres, Acting City Manager, stated that staff included the evaluation and based on the points, staff recommends CBIZ as the consultant to proceed, however, it is up to the Board to decide if there is a deviation.

Chairman Tadeo Azael De La Hoya commented that their contract calls for a change on the Third Party Administrator (TPA) and asked if there will be a change of the TPA.

Ms. Cortez replied that there will not be a change of the TPA.

Chairman Tadeo Azael De La Hoya stated that the recommendation letters are dated 2020 and asked if staff called them just to verify they were doing a good job.

Ms. Cortez responded that staff had already done some research.

MOTION: Vice Chairwoman Emma Torres/Board Member Maria Gonzalez to recommend CBIZ as staff believes this is the best plan. Motion passed with four (4) ayes and one (1) nay by Chairman Tadeo Azael De La Hoya.

The vote was as follows:

Chairman Tadeo Azael De La Hoya	Nay
Vice-Chairwoman Emma Torres	Aye
Board Member Maria Gonzalez	Aye
Board Member Gustavo McGrew	Aye
Maria Sabori, Secretary	Aye

Chairman Tadeo Azael De La Hoya asked if there is financial stability to do both at the same time, because they are starting and they will be paid by the city not the Trust.

Ms. Monica Castro, Director of Finance, indicated that of all the options, CBIZ was the only provider that did not want to negotiate or waive the fees, it will be \$48,000.00 more. She added that the Trust has a very healthy financial position to withstand additional charges. The only thing will be spending an additional \$48,000.00, but the Trust is in the capacity to withstand that additional funding and if that is the preference of the Board to go with that option, the Trust will have the funds to pay for that; therefore the Trust pays for it.

4. ADJOURNMENT

Chairman Tadeo Azael De La Hoya adjourned the meeting at approximately 11:12 a.m.

APPROVED:

Tadeo Azael De La Hoya, Chairman

ATTEST:

Sonia Cornelio, City Clerk

Certification

I hereby certify that the foregoing minutes are a true and correct copy of the Special meeting for the Employee Benefit Trust Board of the City of San Luis, Arizona, held on October 24, 2023. I further certify that the meeting was duly called and held and that a quorum was present.

Sonia Cornelio, City Clerk



AGENDA ITEM REVIEW FORM

Special Employee Benefit Trust Board Meeting

3. A.

Meeting Date: 01/10/2024

Department Head: Adela Cortez, Director Human Resources, Human Resources Department

Submitted By: Maria Barajas Gutierrez, Human Resources Coordinator, Human Resources Department

ITEM:

Discussion and possible action on any and all matters regarding a contract with CBIZ Benefits & Insurance Services, Inc. for employee benefits broker and consultant services. (Kay Marion Macuil, City Attorney)

SUMMARY:

At the last meeting, the Trustee Board chose CBIZ Benefits & Insurance, Inc. ("CBIZ") from the respondents to the Request for Qualifications & Request for Proposals for an employee benefits broker and consultant. The term is for three (3) years with option for the Trust to renew for an additional two (2) years.

The request for proposals section for the solicitation for bids utilized a negotiated fee process. The compensation has been worked out with CBIZ and the staff is recommending approval of the contract.

Below is the fee schedule. Attached is the contract and exhibits.

	A	B	C	D	E	F	G	H	I	J
1	Exhibit C-1 Fee Schedule									
2	CBIZ-City of San Luis Employees Benefits Trust									
3										
4	CBIZ's Original & Submitted Annual Fee Proposal									
5	Contract Years 1 and 2		Contract Years 3 and 4			Contract Year 5				
6	\$96,000 per year		\$102,000 per year			\$108,000 per year				
7										
8	Lump Sum \$48,000 for January 2024-June 2024, calculated at \$8,000 per month									
9										
10	CBIZ Monthly Billed Fees									
11	Contract Year 1		Contract Year 2		Contract Year 3		Extension Contract Year 4		Extension Contract Year 5	
12	Jul-24	\$8,000	Jul-25	\$8,000	Jul-26	\$8,500	Jul-27	\$8,500	Jul-28	\$9,000
13	Aug-24	\$8,000	Aug-25	\$8,000	Aug-26	\$8,500	Aug-27	\$8,500	Aug-28	\$9,000
14	Sep-24	\$8,000	Sep-25	\$8,000	Sep-26	\$8,500	Sep-27	\$8,500	Sep-28	\$9,000
15	Oct-24	\$8,000	Oct-25	\$8,000	Oct-26	\$8,500	Oct-27	\$8,500	Oct-28	\$9,000
16	Nov-24	\$8,000	Nov-25	\$8,000	Nov-26	\$8,500	Nov-27	\$8,500	Nov-28	\$9,000
17	Dec-24	\$8,000	Dec-25	\$8,000	Dec-26	\$8,500	Dec-27	\$8,500	Dec-28	\$9,000
18	Jan-25	\$8,000	Jan-26	\$8,000	Jan-27	\$8,500	Jan-28	\$8,500	Jan-29	\$9,000
19	Feb-25	\$8,000	Feb-26	\$8,000	Feb-27	\$8,500	Feb-28	\$8,500	Feb-29	\$9,000
20	Mar-25	\$8,000	Mar-26	\$8,000	Mar-27	\$8,500	Mar-28	\$8,500	Mar-29	\$9,000
21	Apr-25	\$8,000	Apr-26	\$8,000	Apr-27	\$8,500	Apr-28	\$8,500	Apr-29	\$9,000
22	May-25	\$8,000	May-26	\$8,000	May-27	\$8,500	May-28	\$8,500	May-29	\$9,000
23	Jun-25	\$8,000	Jun-26	\$8,000	Jun-27	\$8,500	Jun-28	\$8,500	Jun-29	\$9,000
24	Totals by Period	\$96,000		\$96,000		\$102,000		\$102,000		\$108,000
25										
26										
27	\$504,000 Grand Total									

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE THE CONTRACT WITH CBIZ BENEFITS & INSURANCE SERVICES, INC., AS PRESENTED.

Attachments

Trust-CBIZ Contract

Exhibit A - CBIZ Response to RFQ-RFP

Exh B & CScope of Work & Fee

PROFESSIONAL SERVICES AGREEMENT

This agreement ("Contract") is made and entered into this ____ day of December 2023, by and between:

City of San Luis Employee Benefits Trust c/o Human Resources Director P.O. Box 1170 San Luis, Arizona 85349 (a municipal trust duly formed by the City of San Luis, Arizona) ("City") and	CBIZ Benefits & Insurance Services, Inc. c/o CBIZ Employee Benefits Division 1765 East Skyline Drive Tucson, Arizona 85718(a for-profit business corporation registered in Arizona and domiciled in Missouri) ("Consultant")

to provide employee benefits brokerage and consultancy services. The City and Consultant may be referred to individually as the Party and collectively as the Parties. In entering this Contract, the Parties have relied upon representations made in the City's Request for Qualifications/Proposal, RFQ/RFP-2023-01, and the Consultant's response to it. Any conflicts between these documents and this Contract, this Contract shall govern the Parties.

WHEREAS, the City desires to retain a consultant to furnish professional services and to make payment for the same in accordance with the terms and conditions set forth in this Contract.

WHEREAS, in procuring these services, the City issued the Request for Qualifications/Proposal, RFQ/RFP No. 2023-01, seeking a qualified broker-consultant to provide employee benefits brokerage and consultancy services.

WHEREAS, upon entering this Contract, the Parties have relied upon representations made in RFQ/RFP No. 2023-01 and the Consultant's response to it.

NOW, THEREFORE, the City agrees to retain and does through this Contract retain the Consultant, and the Consultant agrees to provide the Services required according to the terms and conditions and for the consideration described in this Contract.

CONTRACT DOCUMENTS

In entering this Contract, the Parties have relied upon representations made in the City's Request for Qualifications/Proposal numbered RFQ/RFP-2023-01 and the Consultant's response to it, specifically Exhibit A, titled Offeror Questionnaire, and the Consultant's response to Exhibit A. Any conflicts between these documents and this Contract, this Contract shall govern the Parties.

Exhibit B Scope of Work and Exhibit C-1 Negotiated Fee Schedule are incorporated into this Contract and made a part of it.

1. CONSULTANT'S DUTIES:

- a. Scope of Work: Consultant agrees to perform the professional services as described in Exhibit B, titled Scope of Work, which is incorporated into this Contract by this reference as if set forth in full here. The City shall furnish the Consultant with all data, information, and other support for the scope of work described in Exhibit B.
- b. July 1, 2023, through June 30, 2024: The Consultant is not required to work on the benefits brokered by Susan Posada Agency, Inc. from July 1, 2023, through June 30, 2024. From the execution of this Contract through June 30, 2024, the Consultant's duties in Exhibit B shall be limited to brokering services and presentation of proposals to staff, the City of San Luis Employee Benefits Trust Board, San Luis City Council, and the City of San Luis employees in time for open enrollment and City Council's adoption of the budget in June 2024 for the fiscal year July 1, 2024, through June 30, 2025. The Consultant's duties through June 30, 2024, shall include any other duties necessary or desirable to accomplish the above brokering and presentation duties.

2. **KEY PERSONNEL:** It is essential that the Consultant provide adequate experienced personnel capable of and devoted to the successful accomplishment of work to be performed under this Contract. The Consultant must agree to assign specific individuals to the key positions. The Consultant agrees that, once assigned to work under this Contract, key personnel shall not be removed or replaced without written notice to the City. If key personnel are not available to work under this Contract for a continuous period exceeding thirty calendar days or are expected to devote substantially less effort to the work than initially anticipated, the Consultant shall immediately notify the City and shall replace such personnel with personnel of substantially equal ability and qualifications, subject to the concurrence of the City.

3. **COMPENSATION:** The negotiated fee process shall be utilized for this Contract. For services rendered under this Contract, the Consultant shall be paid in accordance with the negotiated fee schedule in Exhibit C-1, which is incorporated into this Contract by this reference as if set forth in full here. Payment shall be made monthly. The City shall make every effort to process payment for the purchase of materials or services within thirty (30) calendar days after receipt of materials or services and an accurate invoice.

4. TERM AND RENEWAL:

- a. Term: The term of the Contract shall commence upon the award of the Contract and shall remain in effect for a period of three (3) years unless terminated,

canceled, or extended as otherwise provided in this Contract.

- b. **Renewal:** The Consultant agrees that the City shall have the right, at its sole option, to renew the Contract for one (1) additional two-year (2-year) period or portion of a two-year (2-year) period. In the event that the City exercises such right, all terms, conditions, and provisions of the original Contract shall remain the same and apply during the renewal period with the possible exception of price and minor scope additions or deletions or both.

5. **CONSULTANT'S STANDARD OF PERFORMANCE:** While performing the services, the Consultant shall exercise the reasonable professional care and skill customarily exercised by reputable members of the broker-consultant profession. The Consultant shall use reasonable diligence and best judgment while exercising its professional skill and expertise. The Consultant shall be responsible for all errors and omissions the Consultant commits in the performance of this Contract which are a breach of this standard.

6. **CONFIDENTIALITY:** The Consultant, and any subcontractors or individuals hired by the Consultant to perform the services under this Contract, shall keep any information concerning the City matters confidential and agree that they will not make any statement, give any interview or provide any information to any person, corporation or other entity, including without limitation any media source, in relation to the services to be provided under this Contract without the prior written consent of the City. The Consultant, and any subcontractors or individuals hired by the Consultant, agree not to disclose to any other person or entity (unless required by law) any confidential information concerning City matters during and after the termination of this Contract or during or after termination of any extension of services with the Consultant.

7. **NOTICES:** All notices to the other Party required under this Contract shall be in writing and sent by first class certified mail, postage prepaid, return receipt requested, addressed to the following personnel:

If to City: Human Resources Director
 (with copies to
 the City Manager, the Finance Director,
 the City Attorney, and the City Clerk)
 City of San Luis Employee Benefits Trust
 P.O. Box 1170
 San Luis, Arizona 85349

If to Consultant Nancy Mellard
 General Counsel
 CBIZ Employee Benefits
 700 West 47th Street #1100

Kansas City, Missouri 64112

with a copy to
CBIZ Employee Benefits Division
Attention: Oscar Diaz
Vice President of Business Development
1765 East Skyline Drive
Tucson, Arizona 85718

8. TERMINATION:

- a. This Contract may be terminated at any time by mutual written consent.
- b. The City may terminate this Contract with or without cause upon giving the Consultant at least sixty (60) days' written notice to the Consultant.
- c. If this Contract is terminated, the City shall be liable only for payment under the payment provisions of this Contract for services rendered and accepted material received by the City before the effective date of termination. In the event of such termination, the Consultant shall deliver to the City all work in any state of completion or incompleteness at the date of effective termination.
- d. The City reserves the right to cancel the whole or any part of this Contract due to the failure of the Consultant to carry out any term, promise, or condition of the Contract. The City will issue a written ten (10) day notice of default to the Consultant for acting or failing to act as in any of the following:
 - (1) In the opinion of the City, the Consultant provides personnel that do not meet the requirements of the Contract;
 - (2) In the opinion of the City, the Consultant fails to perform adequately the stipulations, conditions, services, or specifications required in this Contract;
 - (3) In the opinion of the City, the Consultant attempts to impose on the City personnel or materials, products, or workmanship that are of an unacceptable quality;
 - (4) Consultant fails to furnish the required service and/or product within the time stipulated in the Contract;
 - (5) In the opinion of the City, the Consultant fails to make progress in the performance of the requirements of the Contract or gives the City a positive indication that the Consultant will not or cannot perform the requirements of the Contract or both.

9. SUBCONTRACTORS: Consultant shall, within ten (10) days after the execution

of this Contract and before awarding any subcontract, furnish City with a list of proposed subcontractors, if any, and shall not employ any subcontractors that City may object to for any reason. Consultant agrees that it is as fully responsible to City for the acts and omissions of its subcontractors and of persons either directly or indirectly employed by them as it is for the acts and omissions of persons directly employed by Consultant. Nothing contained in the Contract shall create any contractual relations between any subcontractor and the City.

- 10. RECORDS:** Records of the Consultant's labor, payroll, and other costs pertaining to this Contract shall be kept on a generally recognized accounting basis and made available to the City for inspection on request. The Consultant shall maintain records for a period of at least two (2) years after termination of this Contract and shall make such records available during that retention period for examination or audit by City personnel during regular business hours.

11. INSURANCE-GENERAL:

- a. **Insurer Qualifications.** Without limiting any obligations or liabilities of the Consultant, the Consultant shall purchase and maintain, at its own expense, hereinafter stipulated minimum insurance with insurance companies duly authorized by the State of Arizona with an AM Best, Inc. rating of A- or above with policies and forms satisfactory to the City. Failure to maintain insurance as specified herein may result in termination of this Contract at the City's option.
- b. **No Representation of Coverage Adequacy.** By requiring insurance herein, the City does not represent that coverage and limits will be adequate to protect the Consultant. The City reserves the right to review any and all of the insurance policies or endorsements or both cited in this Contract. However, the City has no obligation to do so. The City's failure to demand such evidence of full compliance with the insurance requirements set forth in this Contractor or failure to identify any insurance deficiency shall not relieve the Consultant from, nor be construed or deemed a waiver of, its obligation to maintain the required insurance at all times during the performance of this Contract.
- c. **Additional Insured.** All insurance coverage and self-insured retention or deductible portions, except Workers' Compensation or Employer's Liability insurance and Professional Liability insurance, if applicable, shall name, to the fullest extent permitted by law for claims arising out of the performance of this Contract, the City of San Luis, the City of San Luis Employee Benefits Trust, and their elected officials, agents, representatives, officers, directors, officials, employees, and volunteers as Additional Insured (Collectively referred to hereafter as "Covered Claimants") as specified under the respective coverage sections of this Contract.
- d. **Coverage Term.** All insurance required in this Contract shall be maintained in

full force and effect until all work or services required to be performed under the terms of this Contract are satisfactorily performed, completed, and formally accepted by the City unless specified otherwise in this Contract.

- e. **Primary Insurance.** The Consultant's insurance, except Workers' Compensation or Employer's Liability insurance and Professional Liability insurance, if applicable, shall be primary insurance with respect to the performance of this Contract and in the protection of the Covered Claimants as an Additional Insured.
- f. **Claims Made.** In the event any insurance policies required by this Contract are written on a "claims made" basis, coverage shall extend, either by keeping coverage in force or purchasing an extended reporting option, for three (3) years past completion and acceptance of the services. Such continuing coverage shall be evidenced by submission of annual Certificates of Insurance citing applicable coverage is in force and contains the provisions as required herein for the three-year (3-year) period.
- g. **Waiver.** All policies, except for Professional Liability, including Workers' Compensation insurance, shall contain a waiver of rights of recovery (subrogation) against the Covered Claimants for any claims arising out of the work or services of the Consultant. The Consultant shall arrange to have such subrogation waivers incorporated into each policy via formal written endorsement thereto on a blanket basis.
- h. **Policy Deductibles and Self-Insured Retentions.** The policies set forth in these requirements may provide coverage that contains deductibles or self-insured retention amounts. Such deductibles or self-insured retention shall not be applicable with respect to the policy limits provided to the City for the Covered Claimants. The Consultant shall be solely responsible for any such deductible or self-insured retention amount.
- i. **Use of Subcontractors.** If any work under this Contract is subcontracted in any way, the Consultant shall execute a written agreement with the subcontractor containing the indemnification provisions and insurance requirements (unless waived by the City at the City's sole discretion) set forth herein protecting the City, the Covered Claimants, and the Consultant. The Consultant shall be responsible for executing the agreement with the subcontractor or subcontractors and obtaining certificates of insurance verifying the insurance requirements.
- j. **Evidence of Insurance.** Prior to commencing any work or services under this Contract, the Consultant shall furnish the City with certificate(s) of insurance, with formal endorsements as required by this Contract, issued by the Consultant's insurer(s) as evidence that policies are placed with acceptable

insurers as specified herein and provide the required coverages, conditions and limits of coverage specified in this Contract and that such coverage and provisions are in full force and effect. If a certificate of insurance is submitted as verification of coverage, the City shall reasonably rely upon the certificate of insurance as evidence of coverage, but such acceptance and reliance shall not waive or alter in any way the insurance requirements or obligations of this Contract. If any of the above-cited policies expire during the life of this Contract, it shall be the Consultant's responsibility to forward renewal certificates containing all the aforementioned insurance provisions within ten (10) days after the renewal date. It shall be the Consultant's responsibility to notify the City if any of the coverage required under this Contract is dropped or there is a change of carriers. Certificates of insurance shall specifically include the following provisions:

- (1) the City and Covered Claimants are Additional Insureds for the Consultant's Commercial Liability Insurance;
- (2) the Consultant's insurance shall be primary and noncontributory insurance with respect to the performance of the Contract, except Workers' Compensation or Employer's Liability insurance and Professional Liability insurance; and
- (3) all policies, excluding Professional Liability, waive the right of recovery (subrogation) against the City and Covered Claimants for any claims arising out of work or services performed by the Consultant under this Contract.

12. REQUIRED INSURANCE COVERAGE:

- a. **Commercial General Liability.** The Consultant shall maintain an "occurrence" form of Commercial General Liability insurance with an unimpaired limit of not less than \$1,000,000 for each occurrence, a \$1,000,000 Products and Completed Operations Annual Aggregate, and a \$2,000,000 General Aggregate Limit. Such limits may be met in a combination of primary and excess policies. The policy or policies shall cover liability arising from premises, operations, independent contractors, products-completed operations, bodily injury or death, personal injury, advertising injury, and property damage. Coverage under the policy will be at least as broad as ISO policy forms C.G. 00 010 or equivalent thereof, including but not limited to separation of the insured's clause. To the fullest extent allowed by law, for claims arising out of the performance of this Contract, the City and Covered Claimants shall be cited as an Additional Insured under ISO, Commercial General Liability Additional Insured Endorsement form C.G. 20 10, or equivalent, which shall read "Who is an Insured (Section II) is amended to include as an insured the person or organization shown in the Schedule, but only with respect to liability arising out of "your work" for that insured by or for you."

- b. Vehicle Liability. The Consultant shall maintain Business Automobile Liability insurance with a limit of \$1,000,000 for each occurrence on the Consultant's owned, hired, and non-owned vehicles assigned to or used in the performance of the Consultant's work or services under this Contract. Coverage will be at least as broad as ISO coverage code "1" "any auto" policy form CA 00 01 or equivalent thereof. To the fullest extent allowed by law, for claims arising out of the performance of this Contract, the City and the Covered Claimants shall be cited as an Additional Insured under ISO Business Auto policy.
- c. Professional Liability (Errors and Omissions Liability). The Consultant shall maintain Professional Liability insurance covering negligent errors and omissions arising out of the Services performed by the Consultant, anyone employed by the Consultant, or anyone for whose negligent acts, mistakes, errors, and omissions the Consultant is legally liable, with an unimpaired liability insurance limit of \$5,000,000 each claim and \$5,000,000 all claims. In the event the Professional Liability insurance policy is written on a "claims made" basis, the Consultant warrants that any retroactive date under the policy shall precede the effective date of this Contract and that either continuous coverage will be maintained or an extended discovery period will be exercised for a period of three (3) years beginning at the time work under this Contract is completed.
- d. Workers' Compensation Insurance. The Consultant shall maintain Workers' Compensation insurance to cover obligations imposed by federal and state statutes having jurisdiction over the Consultant's employees engaged in the performance of work or services under this Contract and shall also maintain Employers Liability Insurance of not less than \$500,000 for each accident, \$500,000 disease for each employee and \$1,000,000 disease policy limit.

13. RIGHT OF CITY TO CONTRACT WITH OTHERS: Nothing in this Contract shall imply the City is obligated to obtain the services described herein with only this particular Consultant.

14. UNCONTROLLABLE FORCES (also known as *FORCE MAJEURE*): The City and the Consultant shall exert all efforts to perform their respective responsibilities under this Contract. However, neither Party shall hold the other Party responsible for inability to render timely performance if such inability is a direct result of a force beyond the affected Party's control, including but not limited to the following: strikes, lockouts, embargoes, failure of carriers, inability to obtain transportation facilities; acts of God or the public enemy; changes in laws or regulations; emergency executive orders, proclamations, or declarations for disasters or public health emergencies; other events beyond the control of the Party or the Party's employees and agents.

15. INDEMNIFICATION: To the fullest extent allowed by law, the Consultant shall defend, indemnify, and hold the City and Covered Claimants harmless from any

and all loss, damage, claim for damage, liability, expense, or cost, including reasonable attorneys' fees, which arise out of, or is in any way connected with the performance of work under this Contract by the Consultant, or any of the Consultant's employees, agents or subcontractors, and from all claims by the Consultant's employees, subcontractors and agents for compensation for services rendered to the Consultant in the performance of this Contract, notwithstanding that the City may have benefited from their services. This indemnification provision shall only apply to any and all negligent acts or omissions, willful misconduct, or negligent conduct, whether active or passive, on the part of the Consultant or the Consultant's employees, subcontractors, or agents. This section shall survive the expiration or early termination of this Contract.

16. WAIVER OF TERMS AND CONDITIONS: The failure of the City or the Consultant to insist in any one or more instances on the performance of any of the terms or conditions of this Contract or to exercise any right or privilege contained in this Contract shall not be considered as thereafter waiving such terms, conditions, rights, or privileges, and they shall remain in full force and effect.

17. INDEPENDENT CONTRACTOR: The Consultant, at all times during the Consultant's performance of these Contract services, shall retain the Consultant's status as an independent contractor. The Consultant's employees shall under no circumstances be considered or held to be employees or agents of the City of San Luis, Arizona, nor the City of San Luis Employee Benefits Trust. Neither shall have any obligation to pay or withhold state or federal taxes or provide workers' compensation or unemployment insurance for or on behalf of the Consultant's agents or the Consultant. It is clearly understood that each Party shall act in its individual capacity and not as an agent, employee, partner, joint venture, or associate of the other. The City and the Consultant intend that this Contract creates an independent contractor relationship and not an employer-employee relationship. The City is interested only in the results to be achieved and not the conduct and control of the performance of the services contemplated in this Contract. The Consultant's rights include but are not limited to control of the work, manner, and methods of the work, and the right to contract with other entities. The City's rights include but are not limited to inspection and approval of the work and the right to contract with others to perform the work. An employee or agent of one Party shall not be deemed or construed to be the employee or agent of the other Party for any purpose whatsoever. The Consultant shall not be entitled to any City of San Luis employee benefits and shall not be compensated in the form of salaries, paid vacation, or sick days by the City, and such days do not accumulate for the use of the same at a later date.

18. MEDIATION OR ARBITRATION. In the event that there is a dispute under this Contract that the Parties cannot resolve between themselves, the Parties agree to attempt to settle the dispute by mediation or by nonbinding arbitration before the commencement of litigation. The arbitration shall be held under the rules of the

American Arbitration Association. The matter in dispute shall be submitted to an arbitrator mutually selected by the Consultant and the City. In the event that the Parties cannot agree upon the selection of an arbitrator within seven (7) days, then within three (3) days thereafter, the City and Consultant shall request the presiding judge of the Superior Court in and for the County of Yuma, State of Arizona, to appoint an independent arbitrator. The cost of any such arbitration shall be divided equally between the City and the Consultant. The results of the arbitration shall be nonbinding on the Parties, and any Party shall be free to initiate litigation subsequent to the final decision of the arbitrator. If mediation is chosen, the mediator shall be chosen in a manner similar to the arbitrator selection process above.

19. GOVERNING LAW AND VENUE: The terms and conditions of this Contract shall be governed by and interpreted in accordance with the laws of the State of Arizona. Any action at law or in equity brought by either Party for the purpose of enforcing a right or rights provided for in this Contract shall be tried in a court of competent jurisdiction in Yuma County, State of Arizona. By signing this Contract, the Parties waive all provisions of law providing for a change of venue in such proceeding to any other county. In the event either Party shall bring suit to enforce any term of this Contract or to recover any damages for and on account of the breach of any term or condition in this Contract, it is mutually agreed that the prevailing Party in such action shall recover all costs including all litigation and appeal expenses, collection expenses, reasonable attorneys' fees, necessary witness fees, and court costs to be determined by the court and not a jury in such action.

20. OWNERSHIP OF RECORDS AND REPORTS: All of the files, reports, documents, information, and data prepared or assembled by Consultant under this Contract shall be and remain the property of City and shall be forwarded to City at any time City requires such papers.

21. LICENSE: The Consultant represents and warrants that any license necessary to perform the work under this Contract is current and valid. The Consultant understands that the activity described in this Contract may constitute doing business in the City of San Luis. The Consultant agrees to obtain any necessary business license pursuant to Chapter 5.05 of the San Luis City Code and keep such license current during the term of this Contract. Any activity by the Consultant's subcontractors within the corporate city limits will invoke the same business regulations on any subcontractors. The Consultant ensures its subcontractors will obtain any required City of San Luis business license.

22. NO ASSIGNMENT: This Contract has been entered into based upon the personal reputation, expertise, and qualifications of the Consultant. Neither Party to this Contract shall assign its interest in the Contract, either in whole or in part. The Consultant shall not assign any monies due or to become due to it under this

Contract without the prior written consent of the City.

23. THIRD PARTY BENEFICIARIES: There are no third-party beneficiaries of this Contract.

24. ENTIRE AGREEMENT: This Contract and any attachments represent the entire agreement between the City and the Consultant and supersede all prior negotiations, representations, or agreements, either express or implied, written or oral. It is mutually understood and agreed that no alteration or variation of the terms and conditions of this Contract shall be valid unless made in writing and signed by the Parties to this Contract. Written and signed amendments shall automatically become part of the Contract and shall supersede any inconsistent provision therein, provided, however, that any apparent inconsistency shall be resolved, if possible, by construing the provisions as mutually complementary and supplementary.

25. SEVERABILITY: If any part, term, or provision of this Contract shall be held illegal, unenforceable, or in conflict with any law, the validity of the remaining portions and provisions in this Contract shall not be affected.

26. CONFLICTS OF INTEREST: The provisions of A.R.S. § 38-511 relating to cancellation of contracts due to conflicts of interest shall apply to this Contract.

27. IMMIGRATION: To the extent applicable under A.R.S. § 414401, the Consultant and its subcontractors warrant compliance with all federal immigration laws and regulations that relate to their employees and compliance with the E-Verify requirements under A.R.S. § 23-214(A).

- a. The Consultant or subcontractor's breach of the warranty mentioned above shall be deemed a material breach of the Contract and may result in the termination of the Contract by the City.
- b. The City retains the legal right to randomly inspect the papers and records of the Consultant and its subcontractors who work on this Contract to ensure the Consultant and subcontractors are complying with the warranty mentioned above.

28. ISRAEL BOYCOTT: To the extent permitted by law, Consultant shall not participate in and agrees not to participate during the term of this Contract a boycott of Israel in accordance with A.R.S. § 35-393.01.

29. FORCED LABOR: Under A.R.S. § 35-394, the Consultant certifies that the Consultant is not currently engaged in and agrees for the duration of this Contract, it will not use the forced labor of ethnic Uyghurs in the People's Republic of China, any of their goods or services, or use any subcontractors or

supplies that use their forced labor.

- 30. CONTRACT AMENDMENTS:** This Contract shall be modified only by a written contract amendment signed by a duly authorized representative of the City and persons duly authorized to enter into contracts on behalf of the Consultant.
- 31. PROVISIONS REQUIRED BY LAW:** Each and every provision of law and any clause required by law to be in this Contract shall be read and enforced as though it were included in this Contract, and if through mistake or otherwise, any such provision is not inserted, or is not correctly inserted, then upon the application of either Party, the Contract shall be physically amended immediately to make such insertion or correction.
- 32. TIME OF THE ESSENCE:** Time is of the essence in this Contract. Unless otherwise specifically provided, any consent to delay in the Consultant's performance of its obligation is applicable only to the particular transaction to which it relates and is not applicable to any other obligation or transaction.
- 33. HEADINGS:** The headings of this Contract are solely for the convenience of the Parties and shall not be used to explain, modify, simplify, or aid in the interpretation of the provisions of this Contract.
- 34. FURTHER ACTS:** Each of the Parties shall execute and deliver all such documents and perform all such acts as reasonably necessary, from time to time, to carry out the matters contemplated by this Contract.
- 35. COUNTERPARTS:** This Contract may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. The signature pages from one or more counterparts may be removed from such counterparts. Such signature pages may all be attached to a single instrument so that the signatures of all Parties may be physically attached to a single document.
- 36. AUTHORITY:** Each Party represents and warrants to the other Party: (i) that such Party is duly organized and validly existing under the laws of the State of Arizona and has full corporate power and authority to enter into this AGREEMENT and to carry out the provisions of this AGREEMENT; (ii) such Party is duly authorized to execute and deliver this AGREEMENT and to perform its obligations under this AGREEMENT; (iii) the person executing this AGREEMENT on such Party's behalf has been duly authorized to do so by all requisite corporate action, and (iv) this AGREEMENT is a legal and valid obligation binding upon the Parties and enforceable in accordance with its terms.

The Parties have executed this Contract in Arizona on the day and year set forth above, which is the day the last Party signed this Contract.

City of San Luis Employee Benefits Trust

Tadeo Azael De La Hoya
Board of Trustees Chair

Date: _____

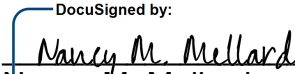
Attest:

Approved As to Form:

Sonia Cornelio, City Clerk

Kay Marion Macuil, City Attorney

CBIZ Benefits & Insurance Services, Inc.

DocuSigned by:


Nancy M. Mellard
Executive Vice President

Date: 12/19/2023

Exhibit B

Scope of Work

EXHIBIT B – SCOPE OF WORK**I. Project Overview**

The City seeks statement of qualifications/proposals from experienced and qualified firms to provide broker-of-record and consulting services for the City's employee benefits programs.

II. Scope of Services

The City seeks qualifications from experienced, compliant with applicable and licensing for the profession, and otherwise qualified firms to provide broker-of-record and consulting services for the City's employee benefits programs including, but not limited to, the City's following programs:

- Health Insurance (*US/Mexico Plan & Mexico Only Plan*)
- Voluntary Dental Insurance (*US/Mexico Plan & Mexico Only Plan*)
- Voluntary Vision Insurance
- Life and Accidental Death & Dismemberment (AD&D) Insurance
- Short-Term and Long
- Section 125 Flexible Spending Accounts
- COBRA - third party administration
- FMLA administration
- Wellness Plan
- Telemedicine
- Employee Assistance Program
- Voluntary Supplemental coverage
- Stop Loss Insurance
- Other Ancillary Benefits as Deemed Appropriate

The broker/consultant selected will provide a full range of consulting and brokerage services in cooperation with the City staff and management. The broker/consultant will assist the City, by performing a full range of services related to the design, implementation, maintenance, communication, and improvement of the City of San Luis group medical, dental, vision, STD/LTD, life insurance coverage and other various benefits as listed above. The broker/consultant will be expected to provide services including, but not limited to, the following:

- **ADMINISTERING ALL GROUP INSURANCE PLANS, RESPONDING TO QUESTIONS FROM AND PROVIDING INFORMATION TO STAFF, AND PROVIDING OTHER CONSULTING SERVICES DURING THE COURSE OF THE PLAN YEAR.**
- **REVIEWING CLAIMS EXPERIENCE, CLAIM SERVICE, AND CLAIM ADMINISTRATION TO ENSURE MAXIMUM BENEFIT TO THE CITY.**
- **DETERMINING AND RECOMMENDING THE MOST ECONOMICAL FUNDING METHODS FOR THE BENEFIT PROGRAMS.**

- **REPRESENTING THE CITY IN ALL NEGOTIATIONS WITH PROVIDERS ON ALL ISSUES INCLUDING THOSE RELATED TO PREMIUMS, BENEFIT LEVELS, PLAN DESIGN, AND SPECIAL TERMS AND CONDITIONS.**
- **MEETING WITH AND PROVIDING REPORTS TO VARIOUS CITY REPRESENTATIVES INCLUDING THE CITY MANAGER, HUMAN RESOURCES DIRECTOR, FINANCE DIRECTOR, AND EMPLOYEE BENEFITS TRUST.**
- **RECOMMENDING ITEMS TO BRING TO THE BOARD OF TRUSTEES' MEETINGS SUCH AS ADDING OR CHANGING PROGRAMS, TRENDS IN CLAIMS. THE BOARD MEETS AT LEAST FOUR TIMES PER YEAR FOR STAFF TO REPORT ON THE TRUST FUND BALANCE AND OTHER TOPICS THE BROKER/CONSULTANT MAY PRESENT AFTER CONSULTATION WITH STAFF. IT IS EXPECTED BROKER/CONSULTANT COMPLY WITH THE BOARD'S DEADLINES, ATTEND TRUST MEETINGS AS NEEDED, AND ADHERE TO THE OPEN MEETING LAW AND BASIC ROBERT'S RULES OF CONDUCT DURING BOARD MEETINGS**
- **ATTENDING THE CITY COUNCIL'S ANNUAL BUDGET MEETING IN APRIL TO EXPLAIN THE UPCOMING PLAN AND FUNDING NEEDED FOR THE PLAN WHICH STARTS ON JULY 1.**
- **IMPLEMENTATION AND FOR THE EMPLOYEES COMMUNICATION OF NEW PROGRAMS OR CHANGES TO EXISTING PROGRAMS (WRITTEN MATERIAL IN ENGLISH & SPANISH), THAT WILL INCLUDE ATTENDING AND PRESENTING INFORMATION AT OPEN ENROLLMENT MEETINGS.**
- **RESEARCHING AND ADVISING THE CITY OF ANY NEW DEVELOPMENTS IN THE STATE AND FEDERAL LAW AND EMPLOYEE BENEFIT PROGRAMS ON AN ONGOING BASIS.**
- **PROVIDING TIMELY COMPLIANCE WITH STATE AND FEDERAL LAWS AND REGULATIONS EXISTING AND AS AMENDMENTS BECOME EFFECTIVE RELATED TO EMPLOYEE BENEFITS AND TO SELF-FUNDED GROUPS IN PARTICULAR.**
- **WORKING WITH A MEXICAN NETWORK PROVIDER INCLUDING BUT NOT LIMITED TO ANALYZING EQUIVALENCES AS NECESSARY TO COMPLY WITH THE ACA AND OTHER LAWS AND REGULATIONS, SEEKING POSSIBILITIES FOR EXPANSION OF THE NETWORK.**
- **MONITORING LAW AND REGULATION FOR CHANGES RELATED TO HEALTH BENEFITS FOR POLICE, FIREFIGHTERS AND AMBULANCE SERVICES PERSONNEL.**

- **PREPARING BID SPECIFICATIONS AND SOLICITING PROPOSALS FROM INSURANCE MARKETS WHICH SPECIALIZE IN GROUP INSURANCE PLANS AS NEEDED. EVALUATE BIDS AND BIDDERS, INCLUDING ADMINISTRATION, CLAIM PAYMENT PROCEDURES, CUSTOMER SERVICE, NETWORK, RESERVE ESTABLISHMENT POLICIES, FINANCIAL SOUNDNESS, AND IDENTIFYING THE MOST COST-BENEFICIAL PACKAGE FROM AMONG THE VARIOUS BIDDERS.**
- **INTERFACING WITH INSURANCE CARRIERS AS NEEDED TO ASSIST THE CITY IN THE RESOLUTION OF PROBLEMS ASSOCIATED WITH THE BENEFIT PROGRAMS.**
- **REVIEWING EXISTING PROGRAMS AND IDENTIFICATION OF RECOMMENDATIONS FOR CHANGES IN PLAN PROVISIONS, ALTERNATIVE DELIVERY SYSTEMS, FUNDING ALTERNATIVES, PREMIUM COST-SHARING AND OTHER AREAS, AS APPROPRIATE.**
- **PROVIDING COMPLETE COBRA ADMINISTRATIVE SERVICES.**
- **PROVIDING EXCELLENT CUSTOMER SERVICE, INCLUDING BUT NOT LIMITED TO TAKING TIME TO LEARN THE ISSUE AT HAND AND PROVIDING APPROPRIATE SOLUTIONS OR OPTIONS.**
- **RESPONDING PROMPTLY TO ALL COMMUNICATIONS FROM THE STAFF AND MANAGEMENT. ADDRESS QUESTIONS, CONCERNS, AND REPORTS OF ISSUES DILIGENTLY AND EXPEDITIOUSLY. PERSONAL SERVICE DIRECTLY WITH THE INDEPENDENT PROFESSIONAL BROKER IS EXPECTED. CALL CENTER SERVICE IS UNACCEPTABLE.**

III. Broker experience and qualifications

The successful broker shall perform the services necessary to evaluate current insurance coverages and services and potentially replace insurance coverage if it's to the benefit of the City.

A. Broker's experience & qualifications

Demonstrate the Broker's knowledge and experience relative to the terms identified under the Scope of Work. Include a list of similar services provided and a description of the Broker's general organization and names of key personnel, indicating the depth and quality of experience.

B. Identification and organization of the proposed team

Please provide the number of licensed employee benefits staff with five (5) years of commercial lines experience, for the following categories:

1. Brokers, and
2. Other professional staff.

C. Additional Information Requested:

1. List Arizona public entity accounts, dates of service, including the name and phone number of the primary contact for similar projects done by the personnel to be involved in these projects.
2. Discuss any additional services the Consultant normally offers in conjunction with providing the lines of insurance that are referenced in the RFQ.

Exhibit C-1

Negotiated Fee Schedule

Exhibit C-1 Fee Schedule
CBIZ-City of San Luis Employees Benefits Trust

CBIZ's Original & Submitted Annual Fee Proposal		
Contract Years 1 and 2	Contract Years 3 and 4	Contract Year 5
\$96,000 per year	\$102,000 per year	\$108,000 per year

Lump Sum \$48,000 for January 2024-June 2024, calculated at \$8,000 per month

CBIZ Monthly Billed Fees									
Contract Year 1		Contract Year 2		Contract Year 3		Extension Contract Year 4		Extension Contract Year 5	
Jul-24	\$8,000	Jul-25	\$8,000	Jul-26	\$8,500	Jul-27	\$8,500	Jul-28	\$9,000
Aug-24	\$8,000	Aug-25	\$8,000	Aug-26	\$8,500	Aug-27	\$8,500	Aug-28	\$9,000
Sep-24	\$8,000	Sep-25	\$8,000	Sep-26	\$8,500	Sep-27	\$8,500	Sep-28	\$9,000
Oct-24	\$8,000	Oct-25	\$8,000	Oct-26	\$8,500	Oct-27	\$8,500	Oct-28	\$9,000
Nov-24	\$8,000	Nov-25	\$8,000	Nov-26	\$8,500	Nov-27	\$8,500	Nov-28	\$9,000
Dec-24	\$8,000	Dec-25	\$8,000	Dec-26	\$8,500	Dec-27	\$8,500	Dec-28	\$9,000
Jan-25	\$8,000	Jan-26	\$8,000	Jan-27	\$8,500	Jan-28	\$8,500	Jan-29	\$9,000
Feb-25	\$8,000	Feb-26	\$8,000	Feb-27	\$8,500	Feb-28	\$8,500	Feb-29	\$9,000
Mar-25	\$8,000	Mar-26	\$8,000	Mar-27	\$8,500	Mar-28	\$8,500	Mar-29	\$9,000
Apr-25	\$8,000	Apr-26	\$8,000	Apr-27	\$8,500	Apr-28	\$8,500	Apr-29	\$9,000
May-25	\$8,000	May-26	\$8,000	May-27	\$8,500	May-28	\$8,500	May-29	\$9,000
Jun-25	\$8,000	Jun-26	\$8,000	Jun-27	\$8,500	Jun-28	\$8,500	Jun-29	\$9,000
Totals by Period	\$96,000		\$96,000		\$102,000		\$102,000		\$108,000

\$504,000 Grand Total

Exhibit A

CBIZ Response

to

RFQ/RFP No. 2023-01

City of San Luis

Employee Benefits Trust

CBIZ Employee Benefits Response to:
The City of San Luis
RFQ/RFP No. 2023-01
Employee Health Benefit Broker/Consultant

Submitted by:

Oscar Diaz, Vice President of Business Development/Consultant

(520) 235-4726

odiaz@cbiz.com

1765 E. Skyline Dr.

Tucson, AZ 85718





OFFER & ACCEPTANCE PAGE
PRICE PROPOSAL PAGE

OFFER & ACCEPTANCE PAGE

TO THE CITY OF SAN LUIS:

The Undersigned hereby offers and shall furnish the material or service in compliance with all terms, scope of work, conditions, specifications, and addenda in the Request for Proposal which is incorporated by reference as if fully set forth herein.

For clarification of this offer, contact:

Name: Adela Cortez

Title: Human Resources Director

Company Name: City of San Luis

Address: 800 E. Cesar Chavez Blvd.

San Luis AZ 85349
City State Zip

Phone: 928-341-8579

Fax: 928-722-6773

E-mail: acortez@sanluisaz.gov

I certify that I am an authorized individual to bind the bidder to the proposal.


Signature of Person Authorized to Sign

Printed Name: Carol L. Morris

Title: Chief Financial Officer - CBIZ Benefits & Insurance Services, Inc.



INTRODUCTION & ACKNOWLEDGEMENT

INTRODUCTION & ACKNOWLEDGEMENT

September 15, 2023

Sonia Cornelio
City Clerk
City of San Luis
1090 East Union Street
P.O. Box 1170
San Luis, AZ 85349

**Re: Request of Qualifications/Proposal (RFQ/RFP)
For Employee Health Benefits Broker/Consultant
RFQ/RFP – 2023-01**

Dear Ms. Cornelio:

Thank you for your invitation to respond to the City of San Luis's aforementioned Request for Qualifications. CBIZ has thoroughly reviewed the requirements and the outlined scope of services and expectations and agrees to meet the requirements as outlined and to provide the services as prescribed. Please note that we will not be using any sub-contractors to deliver services to the City of San Luis.

At CBIZ, we believe the growing complexity of the employee benefits landscape necessitates a benefits partner with the experience and internal resources needed to provide all the services an employer will need. We will offer a fresh look and innovative solutions, unique to the City of San Luis's culture and needs. We will help the City of San Luis make informed decisions that will positively impact your culture, employees, and your organization's bottom line. In addition to this critical guidance, we also focus on helping you to improve operational effectiveness, leaving your team more time to focus on the human elements of their job.

CBIZ Arizona has been working with public sector and governmental employers for over 30 years and within our response you will see that we are thoroughly experienced in providing service to public sector and governmental employers in Arizona (we currently provide service to 25 public sector/governmental employers) and particularly with public sector employers which have Employee/Health Benefits Trusts in place. Furthermore, we are also experienced at working with self-funded employers and employers offering Mexico plans. We have the commensurate, in-house resources available to provide the City of San Luis with full-service employee benefits consulting.

Within our response, we have highlighted all of the resources available to provide the City of San Luis with the types and level of services it seeks to meet its needs, goals, and objectives. Within the document we will highlight our capabilities and will show how CBIZ provides a personalized approach by:

- Implementing **multi-year strategies** and solutions tailored to desired outcomes
- Analyzing opportunities to **improve administrative efficiency** and employee support capabilities
- Using data analytics to identify **cost savings, population health management & budgetary forecasting**
- Creating **dynamic communications** to increase engagement and support cultural initiatives
- **Actuarial validation** of all financial components of your insurance plans
- In-house **pharmacy consulting resources** to assist with the mitigation of costs
- In-house **legislation and compliance, and wellbeing resources**

Thank you again for this opportunity and we look forward to meeting with you soon to review our services and qualifications in greater detail.

Sincerely,

Oscar A. Diaz
Vice President of Business Development/Consultant
(520) 235-4726
odiaz@cbiz.com



ORIGINAL RFP/RFQ Document



**REQUEST FOR QUALIFICATIONS/PROPOSAL
(RFQ/RFP)**

FOR

EMPLOYEE HEALTH BENEFITS BROKER / CONSULTANT

RFQ/RFP-2023-01

**Submission Deadline: Friday, September 15, 2023
No later than 4:00P.M. – Arizona Time**

**City of San Luis
Attention: City Clerk
1090 East Union Street | P.O. Box 1170 | San Luis, Arizona 85349**

NOTICE

NOTICE IS HEREBY GIVEN that the City of San Luis is soliciting sealed statements of qualifications/proposals from independent insurance brokers/consultants qualified to perform and interested in providing brokerage and consulting services for the City of San Luis Employee Benefits Trust. Responses to this notice must specify services and price in detail so as to create an offer that the Trustees of the Health Benefits Program are capable for accepting the best offer to create a binding contract.

This is a professional services RFQ/RFP Notice and is listed on the City's website: www.sanluisaz.gov. Packets are available at the City of San Luis City Hall, 1090 East Union Street | P.O. Box 1170, San Luis, AZ 85349 or via email mlopez@sanluisaz.gov.

Interested and qualified brokers/consultants who have demonstrated their ability at comparable work are invited to submit their statement of qualifications and proposals. Proposals will be received until 4:00 P.M. (Arizona Time) on **Friday, September 15, 2023**.

Submittals and requests for information relative to this Request for Qualifications/Proposal should be addressed to:

Employee Health Benefits Broker/Consultant

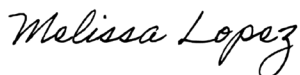
Attn: Sonia Cornelio, City Clerk
City of San Luis
1090 East Union Street | P.O. Box 1170
San Luis, AZ 85349

Written responses and all supporting materials must be submitted in 1 original plus 5 copies and offeror shall also submit one (1) electronic version of their proposal on either a CD or thumb drive, using Word or PDF File.

The City reserves the right to reject any proposal, defer action on proposals and to waive any informality thereof. Any late submissions will not be accepted and will be returned to sender.

Please note that the City of San Luis is not asking for, nor authorizing your solicitation of quotes from insurance carriers.

Dated at San Luis, Arizona this 28th day of August of 2023.



Melissa Lopez
Deputy City Clerk
City of San Luis

TENTATIVE SCHEDULE FOR THE RFP

- Request for Qualifications/Proposal Notice 08-28-2023
- Requests for Clarification Deadline 09-11-2023
- RFQ/RFP Proposals Due Date 09-15-2023 at 4:00 p.m. AZ Time
- Committee Reviews 09-18-2023
- Interviews with selected broker/consultants 09-20 – 09-22-2023
- Selection and Negotiations 09-25 – 09-29-2023
- Recommend Award of Agreement to Trust 10-02-2023

INTRODUCTION

The City of San Luis Employee Benefits Trust (“City”) is seeking competitive proposals from qualified and interested firms to provide Brokerage/Consulting Services for employee insurance and benefits programs. The selected firm will work with the City’s Human Resources staff to ensure the insurance coverage and carriers recommended are the most comprehensive and competitively priced to meet the City’s short-term and long-term benefits strategies.

The Broker/Consultant selected will offer consulting services on a fee for services basis. The City’s benefits plan year runs from July 1 to June 30 with a budget for the year by the third week of April, and open enrollment meetings to be completed no later than June 1 annually.

Current employee insurance benefits programs for which services may be expected include:

- Health Insurance (*US/Mexico Plan & Mexico Only Plan*)
- Voluntary Dental Insurance (*US/Mexico Plan & Mexico Only Plan*)
- Voluntary Vision Insurance
- Life and Accidental Death & Dismemberment (AD&D) Insurance
- Short-Term and Long-Term Disability Insurance
- Section 125 Flexible Spending Accounts
- COBRA - third party administration
- FMLA administration
- Wellness Plan
- Telemedicine
- Employee Assistance Program
- Voluntary Supplemental coverage
- Stop Loss Insurance
- Other Ancillary Benefits as Deemed Appropriate

BACKGROUND

The City of San Luis, Arizona was founded in 1930 and incorporated in 1979. San Luis is an Arizona general law city, operating under the Council-Manager form of government. The Mayor is directly elected to a 4-year term, and the six City Council members are elected to 4-year staggered terms. (Three Council Members are elected every two years.) San Luis is located in Yuma County, at the southwest corner of the State of Arizona, adjacent to the Colorado River and right at the border with San Luis Rio Colorado, Sonora, Mexico and the state of California. Current population is 37,207. Visitors cross the border between both cities on a daily basis, creating a sense of fluidity that impact all aspects of life, culture, language, heritage, environment and most importantly, economy.

The City employs approximately 310 full and 30 part time employees. The City offers its full-time employees and dependents medical, dental, vision, short-term disability and long-term disability (STD/LTD), life insurance coverage and other voluntary supplemental coverage. The City pays 100% of the employee’s premiums and 77% of the employee dependent’s premiums.

The City established a self-funded insurance program for health benefits and created an Employee Health Benefits Trust (the City of San Luis Employee Benefits Trust) for the purpose of management and administration of the Health Benefits Program with annual funding allocated by City Council. There are five trustees, and their executive advisors are San Luis' HR Director, the Finance Director, and City Manager. The City utilizes HealthComp Integrated Solutions for claims administration for health, dental and COBRA. The City offers a US/Mexico PPO Plan that utilizes BC/BS network in the US and SIARMED Network in Mexico; and a Mexico Only Plan that utilizes SIARMED Network. Life insurance is provided by Standard Insurance Company and includes City-paid coverage and voluntary employee paid options for additional coverage. Short-Term Disability Insurance is City-paid and provided by Standard Insurance Company, as well as Long-Term Disability Insurance for non-ASRS employees. Section 125 Flexible Spending Account third party claims administration is provided by American Fidelity and Vision coverage is provided by VSP.

SCOPE OF SERVICES

I. Project Overview

The City seeks statement of qualifications/proposals from experienced and qualified firms to provide broker-of-record and consulting services for the City's employee benefits programs.

II. Scope of Services

The City seeks qualifications from experienced, compliant with applicable and licensing for the profession, and otherwise qualified firms to provide broker-of-record and consulting services for the City's employee benefits programs including, but not limited to, the City's following programs:

- Health Insurance (*US/Mexico Plan & Mexico Only Plan*)
- Voluntary Dental Insurance (*US/Mexico Plan & Mexico Only Plan*)
- Voluntary Vision Insurance
- Life and Accidental Death & Dismemberment (AD&D) Insurance
- Short-Term and Long
- Section 125 Flexible Spending Accounts
- COBRA - third party administration
- FMLA administration
- Wellness Plan
- Telemedicine
- Employee Assistance Program
- Voluntary Supplemental coverage
- Stop Loss Insurance
- Other Ancillary Benefits as Deemed Appropriate

The broker/consultant selected will provide a full range of consulting and brokerage services in cooperation with the City staff and management. The broker/consultant will

assist the City, by performing a full range of services related to the design, implementation, maintenance, communication, and improvement of the City of San Luis group medical, dental, vision, STD/LTD, life insurance coverage and other various benefits as listed above. The broker/consultant will be expected to provide services including, but not limited to, the following:

- **ADMINISTERING ALL GROUP INSURANCE PLANS, RESPONDING TO QUESTIONS FROM AND PROVIDING INFORMATION TO STAFF, AND PROVIDING OTHER CONSULTING SERVICES DURING THE COURSE OF THE PLAN YEAR.**
- **REVIEWING CLAIMS EXPERIENCE, CLAIM SERVICE, AND CLAIM ADMINISTRATION TO ENSURE MAXIMUM BENEFIT TO THE CITY.**
- **DETERMINING AND RECOMMENDING THE MOST ECONOMICAL FUNDING METHODS FOR THE BENEFIT PROGRAMS.**
- **REPRESENTING THE CITY IN ALL NEGOTIATIONS WITH PROVIDERS ON ALL ISSUES INCLUDING THOSE RELATED TO PREMIUMS, BENEFIT LEVELS, PLAN DESIGN, AND SPECIAL TERMS AND CONDITIONS.**
- **MEETING WITH AND PROVIDING REPORTS TO VARIOUS CITY REPRESENTATIVES INCLUDING THE CITY MANAGER, HUMAN RESOURCES DIRECTOR, FINANCE DIRECTOR, AND EMPLOYEE BENEFITS TRUST.**
- **RECOMMENDING ITEMS TO BRING TO THE BOARD OF TRUSTEES' MEETINGS SUCH AS ADDING OR CHANGING PROGRAMS, TRENDS IN CLAIMS. THE BOARD MEETS AT LEAST FOUR TIMES PER YEAR FOR STAFF TO REPORT ON THE TRUST FUND BALANCE AND OTHER TOPICS THE BROKER/CONSULTANT MAY PRESENT AFTER CONSULTATION WITH STAFF. IT IS EXPECTED BROKER/CONSULTANT COMPLY WITH THE BOARD'S DEADLINES, ATTEND TRUST MEETINGS AS NEEDED, AND ADHERE TO THE OPEN MEETING LAW AND BASIC ROBERT'S RULES OF CONDUCT DURING BOARD MEETINGS**
- **ATTENDING THE CITY COUNCIL'S ANNUAL BUDGET MEETING IN APRIL TO EXPLAIN THE UPCOMING PLAN AND FUNDING NEEDED FOR THE PLAN WHICH STARTS ON JULY 1.**
- **IMPLEMENTATION AND FOR THE EMPLOYEES COMMUNICATION OF NEW PROGRAMS OR CHANGES TO EXISTING PROGRAMS (WRITTEN MATERIAL IN ENGLISH & SPANISH), THAT WILL INCLUDE ATTENDING AND PRESENTING INFORMATION AT OPEN ENROLLMENT MEETINGS.**
- **RESEARCHING AND ADVISING THE CITY OF ANY NEW DEVELOPMENTS IN THE STATE AND FEDERAL LAW AND EMPLOYEE BENEFIT PROGRAMS ON AN ONGOING BASIS.**

- **PROVIDING TIMELY COMPLIANCE WITH STATE AND FEDERAL LAWS AND REGULATIONS EXISTING AND AS AMENDMENTS BECOME EFFECTIVE RELATED TO EMPLOYEE BENEFITS AND TO SELF-FUNDED GROUPS IN PARTICULAR.**
- **WORKING WITH A MEXICAN NETWORK PROVIDER INCLUDING BUT NOT LIMITED TO ANALYZING EQUIVALENCES AS NECESSARY TO COMPLY WITH THE ACA AND OTHER LAWS AND REGULATIONS, SEEKING POSSIBILITIES FOR EXPANSION OF THE NETWORK.**
- **MONITORING LAW AND REGULATION FOR CHANGES RELATED TO HEALTH BENEFITS FOR POLICE, FIREFIGHTERS AND AMBULANCE SERVICES PERSONNEL.**
- **PREPARING BID SPECIFICATIONS AND SOLICITING PROPOSALS FROM INSURANCE MARKETS WHICH SPECIALIZE IN GROUP INSURANCE PLANS AS NEEDED. EVALUATE BIDS AND BIDDERS, INCLUDING ADMINISTRATION, CLAIM PAYMENT PROCEDURES, CUSTOMER SERVICE, NETWORK, RESERVE ESTABLISHMENT POLICIES, FINANCIAL SOUNDNESS, AND IDENTIFYING THE MOST COST-BENEFICIAL PACKAGE FROM AMONG THE VARIOUS BIDDERS.**
- **INTERFACING WITH INSURANCE CARRIERS AS NEEDED TO ASSIST THE CITY IN THE RESOLUTION OF PROBLEMS ASSOCIATED WITH THE BENEFIT PROGRAMS.**
- **REVIEWING EXISTING PROGRAMS AND IDENTIFICATION OF RECOMMENDATIONS FOR CHANGES IN PLAN PROVISIONS, ALTERNATIVE DELIVERY SYSTEMS, FUNDING ALTERNATIVES, PREMIUM COST-SHARING AND OTHER AREAS, AS APPROPRIATE.**
- **PROVIDING COMPLETE COBRA ADMINISTRATIVE SERVICES.**
- **PROVIDING EXCELLENT CUSTOMER SERVICE, INCLUDING BUT NOT LIMITED TO TAKING TIME TO LEARN THE ISSUE AT HAND AND PROVIDING APPROPRIATE SOLUTIONS OR OPTIONS.**
- **RESPONDING PROMPTLY TO ALL COMMUNICATIONS FROM THE STAFF AND MANAGEMENT. ADDRESS QUESTIONS, CONCERNS, AND REPORTS OF ISSUES DILIGENTLY AND EXPEDITIOUSLY. PERSONAL SERVICE DIRECTLY WITH THE INDEPENDENT PROFESSIONAL BROKER IS EXPECTED. CALL CENTER SERVICE IS UNACCEPTABLE.**

III. Broker experience and qualifications

The successful broker shall perform the services necessary to evaluate current insurance coverages and services and potentially replace insurance coverage if it's to the benefit of the City.

A. Broker's experience & qualifications

Demonstrate the Broker's knowledge and experience relative to the terms identified under the Scope of Work. Include a list of similar services provided and a description of the Broker's general organization and names of key personnel, indicating the depth and quality of experience.

C. Identification and organization of the proposed team

Please provide the number of licensed employee benefits staff with five (5) years of commercial lines experience, for the following categories:

1. Brokers, and
2. Other professional staff.

D. Additional Information Requested:

1. List Arizona public entity accounts, dates of service, including the name and phone number of the primary contact for similar projects done by the personnel to be involved in these projects.
2. Discuss any additional services the Consultant normally offers in conjunction with providing the lines of insurance that are referenced in the RFQ.

FINANCIAL CONSIDERATIONS

- A. For services rendered under the resulting contract, the City shall pay the Broker/Consultant based on the amounts as agreed upon between the Broker/Consultant and the City which include overhead, profit and all other costs associated with performing services under the Contract.
- B. The fees proposed shall be based on obtaining the types and amounts of coverage and those services consistent with a full-service brokerage house for specified lines of employee benefits. Any other sources of income, revenue, consideration or compensation, including but not limited to commissions and overrides received by the Broker/Consultant in connection with the City's account must be disclosed and either remitted to the City, or subtracted from the City's obligation. Any firm found to be withholding commission/bonus/override information shall be deemed in breach of contract and will be required to remit the outstanding amount to the City and may result in termination of the contract.

- C. Progress payments will be made consistent with City procedures. The Broker/Consultant shall prepare Pay Requests for the amount representing the actual value of the services rendered and submit these forms to the Human Resources Director for approval and processing.
- D. Broker/Consultant shall not be reimbursed for normal business use mileage. Vehicle usage, lodging, and per diem expenses for out of City consultants must be identified and approved in the broker/consultant's cost proposal.
- E. Reimbursable Expenses (*which are all not-to-exceed allowances*) shall be paid at cost to consultant and shall include no markup. Pay Requests shall be submitted with documentation of incurred expenses for reimbursement as approved expenses are incurred but not to exceed the amount agreed upon by the Broker/Consultant and the City.

INSTRUCTIONS TO OFFERORS

1. Proposal Format:

- a. **Original and 5 copies (6 total) of each proposal** should be submitted on the forms and in the format specified in the RFQ/RFP.
- b. The original copy of the proposal should be clearly labeled "**Original**" and shall be unbound and single-sided. The material should be in sequence and related to the RFQ/RFP. **The sections of the submittal should be tabbed, clearly identifiable and shall include a minimum of the following sections: Price, Offer and Acceptance, Original RFQ/RFP, Evaluation Criteria.**
- c. Proposal shall not exceed a total of twenty-five (25) pages.
- d. The City will not provide any reimbursement for the cost of developing or presenting proposals in response to this RFQ/RFP.
- e. Failure to include the requested information may have a negative impact on the evaluation of the offeror's proposal.

2. Preparation of Proposal:

- b. All proposals shall be on the forms provided in this Request for Qualifications/Proposal package. It is permissible to copy these forms as required.
- c. The Offer and Acceptance page shall be submitted with an original ink signature by the person authorized to sign the proposal.
- d. Erasures, interlineations, or other modifications in the proposal shall be initiated by the authorized person signing the offer.
- e. If price is a consideration and in case of error of prices in the proposal, the unit price shall govern.
- f. Periods of time, stated as a number of days, shall be calendar days.
- g. It is the responsibility of all Offerors to examine the entire RFQ/RFP package and seek clarification of any item or requirements and to check all responses for accuracy before submitting a proposal. Negligence in preparing a proposal confers no right of withdrawal after due time and date.

- h. Signatures. All responses are required to be signed by an authorized representative of the responding entity. Proposals received unsigned will not be accepted.
- i. It is the Offeror's responsibility to prepare an RFQ/RFP, which is representative of the Offeror's qualifications. If there is any additional information which would assist the City in its assessment of the RFQ/RFP, the Offeror should include all such information in its RFQ/RFP under the title Additional Information.
- j. Each proposal shall be prepared simply and economically, avoiding the use of elaborate promotional material beyond what is sufficient to provide a complete and accurate representation. The responses to this Request for Qualifications/Proposals must be made in accordance with the format set forth in this Section. Only RFQ/RFPs that have been determined to be responsive will be considered. Failure to adhere to the following format may cause rejection of the RFQ/RFP as non-responsive.

3. Submittal:

- a. In order to be considered, the Offeror must complete and submit their proposal to the City of San Luis, Office of the City Clerk in the location indicated, prior to the exact time and date indicated on the Notice of Request for Qualifications/Proposal page.
- b. The Offeror's proposal shall be presented in two sealed envelopes. On one, the words "**SEALED QUALIFICATIONS**" with Consultant's Name, Service Description, **RFQ/RFP No. 2023-01**, Date and Time of the qualifications Opening shall be written on the envelope. On the other the words "**SEALED PROPOSAL**" with Consultant's Name, Service Description, **RFQ/RFP No. 2023-01**, Date and Time of Proposal Opening shall be written on the envelope.

- 4. Offer and Acceptance Period:** In order to allow for an adequate evaluation, the City requires an offer in response to this solicitation to be valid and irrevocable for ninety (90) days after opening time and date.

5. Inquiries:

- a. Any question related to the Request for Qualifications/Proposal shall be directed in writing or via e-mail no later than five (5) calendar days prior to the submission date, to the person whose name appears on the front page. Questions submitted after that period may not be answered due to time constraints.
- b. Any correspondence related to the Request for Qualifications/Proposal should refer to the appropriate **RFQ/RFP No. 2023-01**, page, and paragraph number.
- c. The Offeror shall not contact or ask questions of the department for whom the requirement is being procured.
- d. Oral interpretations or clarifications will be without legal effect.
- e. Only questions answered by formal written Request for Qualifications/Proposal Amendment will be binding.

- 6. Request for Additional Information:** The City reserves the right to request additional information from Offerors for the purposes of explaining the contents of their proposal. Any such request shall be for informational purposes only and does not constitute

discussions as defined by the San Luis Procurement Code and this Request for Qualifications/Proposal.

7. **Protests:** A protest shall be in writing and shall be filed with the Human Resources Director. A protest of a Request for Qualifications/Proposal shall be received at the Human Resources Department before the Request for Qualifications/Proposal opening date. A protest of a proposed award or of an award shall be filed within ten days after the protestor knows or should have known the basis of the protest. A protest shall include:
 - a. The name, address, and telephone number of the protestor;
 - b. The signature of the protestor or its representative;
 - c. Identification of the Request for Qualifications/Proposal or contract number;
 - d. A detailed statement of the legal and factual grounds of protest including copies of relevant documents; and,
 - e. The form of relief requested.
8. **Contract Negotiations:** The City reserves the right to enter into discussions with the Offeror(s) determined to be reasonably susceptible of being selected for award, or to enter into exclusive discussions with the Offeror whose proposal is deemed most advantageous, whichever is in the City's best interest, for the purpose of negotiation. In the event that exclusive negotiations are conducted and an agreement is not reached, the City reserves the right to enter into negotiations with the next highest ranked Offeror without the need to repeat the formal solicitation process.
9. **Award of Contract:** Notwithstanding any other provision of the Request for Qualifications/ Proposal, the City reserves the right to:
 - a. Waive any immaterial defect or informality; or
 - b. Reject any or all proposals, or portions thereof; or
 - c. Reissue the Request for Qualifications/Proposal.

A response to any Request for Qualifications/Proposal is an Offer to contract with the City based upon the terms, conditions, and specifications contained in the City's Request for Qualifications/Proposal. Proposals do not become contracts unless and until they are executed by an authorized representative of the Board of Trustees and an authorized representative of the selected Broker/Consultant firm. A contract has its inception in the award, eliminating a formal signing of a separate contract. For that reason, all of the terms and conditions of the contract are contained in the Request for Qualifications/Proposal, unless any of the terms and conditions are modified by a Request for Qualifications/Proposal Amendment, a Contract Amendment, or by mutually agreed terms and conditions in the contract documents.

10. **Familiarization of Scope of Work:** Before submitting a proposal, each Offeror shall familiarize itself with the Scope of Work, laws, regulations and other factors affecting performance of work. It shall carefully correlate its observations with requirements of the Contract and otherwise satisfy itself as to the expense and difficulties attending the performance of the work. The submission of a Proposal will constitute a representation

of compliance by the Offeror. There will be no subsequent financial adjustment, other than that provided by the Contract, for lack of such familiarization.

11. **Late Proposals:** Late proposals shall not be considered.
12. **Withdrawal of Proposal:** At any time prior to the specified deadline and time, an Offeror (or designated representative) may withdraw the offer, by providing notice to the email acortez@sanluisaz.gov.
12. **Amendment of Request for Proposals:** The Offeror shall acknowledge receipt of a Request for Qualifications/Proposal Amendment by signing and returning the document by the specified due time and date.
13. **Submittal:** The Offer and Contract Award sheet, the Pricing Schedule, and any solicitation amendments must be signed and returned with the Offeror's proposal.
14. **Confidential Information:** All materials submitted as part of a response to a solicitation are subject to Arizona public records law and will be disclosed if there is an appropriate public records request at the time of or after the award of the contract. If a person believes that any portion of a proposal, bid, offer, specification, protest, or correspondence contains information that should be withheld from public disclosure, then the Human Resources Director should be so advised in writing (*price is not confidential and will not be withheld*). The City shall review all requests for confidentiality and provide a written determination. If the confidential request is denied, such information shall be disclosed as public information, unless the person utilizes the "Protest" provision.
15. **Subcontractors:** Offeror must list any subcontractor to be utilized in performance of services herein. For each subcontractor, detail on respective qualifications must be included.
16. **Upon Notice of Intent to Award:** The apparent successful offeror shall sign and file with the City, within ten (10) days after Notice of Intent to Award, all documents necessary to the successful execution of the contract.
17. **Proposal Rejection:** Submission of additional terms, conditions and/or agreements with the proposal may result in proposal rejection.
18. **Proposal Results:** Proposal results **are not** provided in response to telephone inquiries. A tabulation of proposals received shall be on file in the Human Resources Department and available for review after contract award.
19. **Vendor Application:** Prior to the award of a contract, the successful offeror shall have a completed vendor application on file with the Finance Department.

20. Vendor Submittal Checklist

- _____ Offer Page (first page of RFQ/RFP packet)
- _____ Introduction
- _____ Acknowledgment
- _____ Qualification of Offeror
- _____ Qualification of Staff
- _____ References
- _____ Work Samples
- _____ License copies included (if applicable)
- _____ Offeror Questionnaire (Exhibit A)
- _____ Scope of Work (Exhibit B)
- _____ Professional Services Agreement (Exhibit C)
- _____ Completed Substitute W-9 form (Exhibit D)
- _____ Conflict of Interest Disclosure (Exhibit E)

EVALUATION

I. SELECTION COMMITTEE

- A. A Selection Committee will be established to evaluate Responses to the RFQ/RFP and recommend the award the contract to the Board of Trustees.
- B. The City will enter into negotiations with a qualified company and execute a contract in substantially similar format to that in Exhibit C upon completion of negotiation of fees and contract terms. The City may decide to terminate the selection process at any time.
- C. The Selection Committee will evaluate all submissions based on qualifications, service provided, ability of professional personnel, past record, experience, ability to complete processes in a timely manner, quality of detail of professional references, and other information made available to the Selection Committee during the evaluation and reference processes.
- D. Other qualifications will be evaluated as needed.

II. EVALUATION CRITERIA – (listed in relative order of importance)

A. Proposal Format	5%
B. Qualifications, Experience and Expertise	20%
C. Method of Approach / Scope of Work	20%
D. Price Proposal	25%
E. Consultant Questionnaire	10%
F. Work Samples	5%
G. Interview	15%

II. REQUIREMENTS SPECIFIC TO EVALUATION CRITERIA:

A. Proposal Format

The narrative portion and the materials presented in response to this Request for Qualifications/Proposal should be submitted in the same order as requested.

B. Qualifications, Experience and Expertise

1. Preferred Qualifications of Offeror
 - a. 10+ years as a licensed insurance broker
 - b. 5+ years of experience as a municipal broker or relevant comparable industries and verticals
 - c. Arizona office location
2. Brief history of the Offeror's agency, including:
 - a. How long the Offeror have been in business performing services as requested in the Scope of Work.
 - b. Agency's experience working with public entities, specifically municipalities.
 - c. Agency's experience working with benefit plans offering coverage in Mexico and experience with self-funded groups.
 - d. Agency's willingness to separate broker fees from premiums to allow for transparency in billing and actual costs? If not, what is the method of transparency?
 - e. Creative ways of how the agency has helped clients reduce costs while still providing a strong benefits package.
3. Identification of agency's professional staff who will comprise a dedicated service team to perform services under this contract. Include office locations, relevant experience with similar sized organizations and municipalities and how your team will meet and exceed the expectations and requirements set forth in this RFQ/RFP.
4. Identification of Sub-Consultants. If any, explain:
 - a. What aspect of the project will they work on and what are their qualifications.

- b. What is your agency's previous experience working with the proposed Sub-Consultants.

5. Professional References

List of three (3) former or current clients who have, within the last five (5) years, contracted the Offeror for services similar to those described in this RFQ/RFP. Include name, title, address, telephone number and email addresses.

C. Method of Approach / Work Scope

Offeror shall prepare a detailed Method of Approach, which indicates the service proposed to be performed by the Offeror. This should address in depth, how Offeror plans to meet the requirements of the Scope of Services of the RFP. The method and approach should be addressed in a manner that reflects understanding and commitment to providing services as needed in a professional and timely manner.

D. Price of Proposal

Propose firm, fee for the provision of services described in this RFP. In addition, provide fully loaded rates including direct and indirect costs and overhead and profit margin for additional services that may be required. The fees proposed shall be based on obtaining the types and amounts of coverage and those services consistent with a full-service brokerage house for specified lines of employee benefits. Any other sources of income, revenue, consideration or compensation, including but not limited to commissions and overrides received by the Broker/Consultant in connection with the City's account must be disclosed and either remitted to the City, or subtracted from the fee received from the City of San Luis.

E. Consultant Questionnaire

Provide responses and information as requested on the Offeror Questionnaire attached as Exhibit A.

F. Work Samples

Provide a sample benefits guide and/or samples of marketing/communication to end users.

III. GENERAL

A. Shortlist:

The City reserves the right to shortlist the Offerors on all of the stated criteria. However, the City may determine that shortlisting is not necessary.

B. Interviews:

The City reserves the right to conduct interviews with some or all of the offerors at any point during the evaluation process. However, the City may determine that interviews are not necessary. In the event interviews are conducted, information provided during the interview process shall be taken into consideration when

evaluating the stated criteria. The City shall not reimburse the offeror for the costs associated with the interview process.

C. Additional Investigations:

The City reserves the right to make such additional investigations as it deems necessary to establish the competence and financial stability of any offeror submitting a proposal.

D. Prior Experience:

Experiences with the City and entities that evaluation committee members represent may be taken into consideration when evaluating qualifications and experience.

E. Contract:

The resultant Contract between the City and the Consultant shall include:

1. RFQ/RFP, including instructions, terms and conditions, scope of work, attachments, and any amendments thereto,
2. The offer submitted by the Offeror in response to the RFQ/RFP and any additional changes or amendments mutually negotiated, including the Not to Exceed Fee for services.
3. The Professional Services Agreement is provided with the solicitation (Exhibit C). It is the Offeror's responsibility to review these documents and identify any conflicts/issues as part of the proposal. Please note that the Contract is subject to revisions suggested by the City Manager.
4. In the event of a conflict in language between the solicitation, the contract of the offer, the provisions and requirements of the contract shall govern. In addition, the contract shall be amended in the case of a conflict in the manner stated in the contract. The order of priority shall be the following:
 - a. Contract - City of San Luis Professional Services Agreement
 - b. RFQ Solicitation
 - c. Offer

F. RIGHTS AND REMEDIES: No provision in this document or in the Consultant's proposal shall be construed, expressly or by implication as a waiver by either party of any existing or future right and/or remedy available by law in the event of any claim or default or breach of contract. The failure of either party to insist upon the strict performance of any term or condition of the contract or to exercise or delay the exercise of any right or remedy provided in the contract, or by law, or the acceptance of materials or services, obligations imposed by this contract or by law, and shall not be deemed a waiver of any right of either party to insist upon the strict performance of the contract.

G. COST OF PROPOSAL PREPARATION: The City shall not reimburse the cost of developing, presenting, or providing any response to this solicitation. Offers submitted for consideration should be prepared simply and economically providing adequate information in a straightforward and concise manner.

H. DEFINITION OF KEY WORDS USED IN THE SOLICITATION:

Shall, Will, Must: Indicate a mandatory requirement. Failure to meet these mandatory requirements may result in the rejection of proposal as non-responsive.

Should: Indicates something that is recommended but not mandatory. If the offeror fails to provide recommended information, the City may, at its sole option, ask the offeror to provide the information or evaluate the proposal without the information.

May: Indicates something that is not mandatory but permissible.

I. PRE-PROPOSAL CONFERENCE:

If scheduled, the date and time of a Pre-Proposal conference is indicated on the cover page of this document. Attendance at this conference is not mandatory.

1. The purpose of this conference will be to clarify the contents of this Request for Qualifications/Proposal in order to prevent any misunderstanding of the City's position.
2. Any doubt as to the requirements of this Request for Qualifications/Proposal or any apparent omission or discrepancy should be presented to the City at this conference.
3. The City will then determine the appropriate action necessary, if any, and may issue a written addendum to the Request for Qualifications/Proposal.
4. Oral statements or instructions will not constitute an addendum to this Request for Proposal.

J. SOLICITATION ADDENDUM:

The Offeror shall acknowledge receipt of a solicitation addendum by signing and returning the document by the specified due date and time. The Request for Qualifications/Proposals with Information for Respondents, Supplemental Project Information, any future Addenda may be obtained from the City's website at www.sanluisaz.gov/bids. **It is the sole responsibility of the Respondent to obtain, review, and acknowledge any addenda that may be published on the City's website.**

K. EXCEPTIONS TO CONTRACT PROVISIONS:

A response to any solicitation is an offer to contract with the City based upon the contract provisions contained in the, the Exhibit B, scope of work and Exhibit C, the service agreement.

1. Offerors who wish to propose modifications to the contract provisions must clearly identify the proposed deviations and any proposed substitute language.
2. The provisions of the contract cannot be modified without the express written approval of the City's HR Director in consultation with the other Executive Advisors of the Trustees.
3. If a proposal or offer is returned with modifications to the contract provisions that are not expressly approved in writing by the HR Director consultation with the other Executive Advisors of the Trustees. in the contract provisions

contained in the City's solicitation document and standard contract shall prevail.

4. NO EXCEPTIONS OR REVISIONS TO THE INDEMNIFICATION PROVISION OF THE STANDARD CONTRACT SHALL BE CONSIDERED.

L. PUBLIC RECORD: All proposals submitted in response to this request shall become the property of the City and shall become a matter of public record available for review subsequent to the award notification.

PRICE PROPOSAL PAGE

Offeror shall provide a charge or fee for provision of all services described herein and in accordance with the following fee schedule. Propose firm, fee for the provision of services described in this RFP. In addition, provide fully loaded rates including direct and indirect costs and overhead and profit margin for additional services that may be required. The fees proposed shall be based on obtaining the types and amounts of coverage and those services consistent with a full-service brokerage house for specified lines of employee benefits. Any other sources of income, revenue, consideration, or compensation, including but not limited to commissions and overrides received by the Broker/Consultant in connection with the City's account must be disclosed and either remitted to the City, or subtracted from the fee received from the City of San Luis.

1. This fee proposal shall include all work necessary to effectively conduct and complete the Scope of Services. The fees stated below must include all necessary costs including, but not limited to, labor, materials, overhead, administrative charges, profit and insurance.

\$ _____
Amount in Figures

Amount in Words

2. Consultant shall provide proposed hourly rates for any additional services not listed under the Scope of Services.

OFFER & ACCEPTANCE PAGE

TO THE CITY OF SAN LUIS:

The Undersigned hereby offers and shall furnish the material or service in compliance with all terms, scope of work, conditions, specifications, and addenda in the Request for Proposal which is incorporated by reference as if fully set forth herein.

For clarification of this offer, contact:

Name: Adela Cortez

Title: Human Resources Director

Company Name: City of San Luis

Address: 800 E. Cesar Chavez Blvd.

<u>San Luis</u>	<u>AZ</u>	<u>85349</u>
City	State	Zip

Phone: 928-341-8579

Fax: 928-722-6773

E-mail: acortez@sanluisaz.gov

I certify that I am an authorized individual to bind the bidder to the proposal.

Signature of Person Authorized to Sign

Printed Name: _____

Title: _____

EXHIBIT A – OFFEROR QUESTIONNAIRE

1. Provide a comprehensive statement about your capacity to meet the City's needs as outlined in this RFP, emphasizing your range of services available to help us provide the best quality, breadth and flexibility of coverage for our employees, while maximizing the value of our premium dollars. Outline specific details of each service you propose.
2. Describe your approach when first working with a new client. How does this approach differ over time with clients with whom you have an established working relationship?
3. Please give a high-level overview, methodology or work plan of how your company would assist the City in developing its overall employee insurance benefits strategy.
4. Describe the methods your firm uses to evaluate healthcare carriers when determining those that would be suitable for providing the services and pricing required by your clients. Also, based on what you may know about the City, are there specific carriers to whom you would market the City's healthcare insurance requirements?
5. Aside from pricing, what criteria do you recommend that your clients should use in evaluating and selecting specific insurance carriers.
6. What is your process for reviewing a client's existing benefits programs and determining whether to make recommendations for changes in carriers, benefits offered, funding strategies or other changes to the total benefits package of products and services?
7. How many clients do you service in the 250-500 covered lives range?
 - a. Which, if any of these, are governmental entities?
 - b. What are the specific employee benefits issues that are faced by organizations in this size range in today's benefits market?
8. Provide examples of the employee communications materials you provide, if any.
9. Describe your ability and experience with
 - a. self-funded insurance plans.
 - b. Plans offering coverage in Mexico.
10. Describe your firm's experience in securing, monitoring and evaluating third party claims administrators on behalf of your clients?
11. Demonstrate your ability to tailor plans for an organization based on available funds and programs and related to employee needs.
12. Demonstrate your ability to tailor innovative plans and how might this help manage overall long-term health costs?

13. Explain what resources/methods you use for pharmacy cost control?
14. Describe your capacity, ability, and experience offering employee wellness programs to promote healthy lifestyles and reduce exposure to long term health costs.
15. Other than the lines of coverage specified in this RFP, describe other lines of coverage for which your firm has expertise.
16. What special capabilities or attributes does your firm have that makes your firm the best choice for the City of San Luis?
17. Provide three (3) reference names and contact telephone numbers for other current clients in the general size range of the City, whom we may contact.

EXHIBIT B – SCOPE OF WORK

I. Project Overview

The City seeks statement of qualifications/proposals from experienced and qualified firms to provide broker-of-record and consulting services for the City's employee benefits programs.

II. Scope of Services

The City seeks qualifications from experienced, compliant with applicable and licensing for the profession, and otherwise qualified firms to provide broker-of-record and consulting services for the City's employee benefits programs including, but not limited to, the City's following programs:

- Health Insurance (*US/Mexico Plan & Mexico Only Plan*)
- Voluntary Dental Insurance (*US/Mexico Plan & Mexico Only Plan*)
- Voluntary Vision Insurance
- Life and Accidental Death & Dismemberment (AD&D) Insurance
- Short-Term and Long
- Section 125 Flexible Spending Accounts
- COBRA - third party administration
- FMLA administration
- Wellness Plan
- Telemedicine
- Employee Assistance Program
- Voluntary Supplemental coverage
- Stop Loss Insurance
- Other Ancillary Benefits as Deemed Appropriate

The broker/consultant selected will provide a full range of consulting and brokerage services in cooperation with the City staff and management. The broker/consultant will assist the City, by performing a full range of services related to the design, implementation, maintenance, communication, and improvement of the City of San Luis group medical, dental, vision, STD/LTD, life insurance coverage and other various benefits as listed above. The broker/consultant will be expected to provide services including, but not limited to, the following:

- **ADMINISTERING ALL GROUP INSURANCE PLANS, RESPONDING TO QUESTIONS FROM AND PROVIDING INFORMATION TO STAFF, AND PROVIDING OTHER CONSULTING SERVICES DURING THE COURSE OF THE PLAN YEAR.**
- **REVIEWING CLAIMS EXPERIENCE, CLAIM SERVICE, AND CLAIM ADMINISTRATION TO ENSURE MAXIMUM BENEFIT TO THE CITY.**
- **DETERMINING AND RECOMMENDING THE MOST ECONOMICAL FUNDING METHODS FOR THE BENEFIT PROGRAMS.**

- **REPRESENTING THE CITY IN ALL NEGOTIATIONS WITH PROVIDERS ON ALL ISSUES INCLUDING THOSE RELATED TO PREMIUMS, BENEFIT LEVELS, PLAN DESIGN, AND SPECIAL TERMS AND CONDITIONS.**
- **MEETING WITH AND PROVIDING REPORTS TO VARIOUS CITY REPRESENTATIVES INCLUDING THE CITY MANAGER, HUMAN RESOURCES DIRECTOR, FINANCE DIRECTOR, AND EMPLOYEE BENEFITS TRUST.**
- **RECOMMENDING ITEMS TO BRING TO THE BOARD OF TRUSTEES' MEETINGS SUCH AS ADDING OR CHANGING PROGRAMS, TRENDS IN CLAIMS. THE BOARD MEETS AT LEAST FOUR TIMES PER YEAR FOR STAFF TO REPORT ON THE TRUST FUND BALANCE AND OTHER TOPICS THE BROKER/CONSULTANT MAY PRESENT AFTER CONSULTATION WITH STAFF. IT IS EXPECTED BROKER/CONSULTANT COMPLY WITH THE BOARD'S DEADLINES, ATTEND TRUST MEETINGS AS NEEDED, AND ADHERE TO THE OPEN MEETING LAW AND BASIC ROBERT'S RULES OF CONDUCT DURING BOARD MEETINGS**
- **ATTENDING THE CITY COUNCIL'S ANNUAL BUDGET MEETING IN APRIL TO EXPLAIN THE UPCOMING PLAN AND FUNDING NEEDED FOR THE PLAN WHICH STARTS ON JULY 1.**
- **IMPLEMENTATION AND FOR THE EMPLOYEES COMMUNICATION OF NEW PROGRAMS OR CHANGES TO EXISTING PROGRAMS (WRITTEN MATERIAL IN ENGLISH & SPANISH), THAT WILL INCLUDE ATTENDING AND PRESENTING INFORMATION AT OPEN ENROLLMENT MEETINGS.**
- **RESEARCHING AND ADVISING THE CITY OF ANY NEW DEVELOPMENTS IN THE STATE AND FEDERAL LAW AND EMPLOYEE BENEFIT PROGRAMS ON AN ONGOING BASIS.**
- **PROVIDING TIMELY COMPLIANCE WITH STATE AND FEDERAL LAWS AND REGULATIONS EXISTING AND AS AMENDMENTS BECOME EFFECTIVE RELATED TO EMPLOYEE BENEFITS AND TO SELF-FUNDED GROUPS IN PARTICULAR.**
- **WORKING WITH A MEXICAN NETWORK PROVIDER INCLUDING BUT NOT LIMITED TO ANALYZING EQUIVALENCES AS NECESSARY TO COMPLY WITH THE ACA AND OTHER LAWS AND REGULATIONS, SEEKING POSSIBILITIES FOR EXPANSION OF THE NETWORK.**
- **MONITORING LAW AND REGULATION FOR CHANGES RELATED TO HEALTH BENEFITS FOR POLICE, FIREFIGHTERS AND AMBULANCE SERVICES PERSONNEL.**

- **PREPARING BID SPECIFICATIONS AND SOLICITING PROPOSALS FROM INSURANCE MARKETS WHICH SPECIALIZE IN GROUP INSURANCE PLANS AS NEEDED. EVALUATE BIDS AND BIDDERS, INCLUDING ADMINISTRATION, CLAIM PAYMENT PROCEDURES, CUSTOMER SERVICE, NETWORK, RESERVE ESTABLISHMENT POLICIES, FINANCIAL SOUNDNESS, AND IDENTIFYING THE MOST COST-BENEFICIAL PACKAGE FROM AMONG THE VARIOUS BIDDERS.**
- **INTERFACING WITH INSURANCE CARRIERS AS NEEDED TO ASSIST THE CITY IN THE RESOLUTION OF PROBLEMS ASSOCIATED WITH THE BENEFIT PROGRAMS.**
- **REVIEWING EXISTING PROGRAMS AND IDENTIFICATION OF RECOMMENDATIONS FOR CHANGES IN PLAN PROVISIONS, ALTERNATIVE DELIVERY SYSTEMS, FUNDING ALTERNATIVES, PREMIUM COST-SHARING AND OTHER AREAS, AS APPROPRIATE.**
- **PROVIDING COMPLETE COBRA ADMINISTRATIVE SERVICES.**
- **PROVIDING EXCELLENT CUSTOMER SERVICE, INCLUDING BUT NOT LIMITED TO TAKING TIME TO LEARN THE ISSUE AT HAND AND PROVIDING APPROPRIATE SOLUTIONS OR OPTIONS.**
- **RESPONDING PROMPTLY TO ALL COMMUNICATIONS FROM THE STAFF AND MANAGEMENT. ADDRESS QUESTIONS, CONCERNS, AND REPORTS OF ISSUES DILIGENTLY AND EXPEDITIOUSLY. PERSONAL SERVICE DIRECTLY WITH THE INDEPENDENT PROFESSIONAL BROKER IS EXPECTED. CALL CENTER SERVICE IS UNACCEPTABLE.**

III. Broker experience and qualifications

The successful broker shall perform the services necessary to evaluate current insurance coverages and services and potentially replace insurance coverage if it's to the benefit of the City.

A. Broker's experience & qualifications

Demonstrate the Broker's knowledge and experience relative to the terms identified under the Scope of Work. Include a list of similar services provided and a description of the Broker's general organization and names of key personnel, indicating the depth and quality of experience.

B. Identification and organization of the proposed team

Please provide the number of licensed employee benefits staff with five (5) years of commercial lines experience, for the following categories:

1. Brokers, and
2. Other professional staff.

C. Additional Information Requested:

1. List Arizona public entity accounts, dates of service, including the name and phone number of the primary contact for similar projects done by the personnel to be involved in these projects.
2. Discuss any additional services the Consultant normally offers in conjunction with providing the lines of insurance that are referenced in the RFQ.

EXHIBIT C – PROFESSIONAL SERVICES AGREEMENT

This agreement (“Contract”) is made and entered into this _____ day of _____, 2023, by and between the San Luis Employee Health Benefit Trust (“City”), and _____ (“Consultant”), to provide Employee Benefits Brokerage and Consultation Services (“Services”).

WHEREAS, City desires to retain a consultant to furnish Professional services and to make payment for the same in accordance with the terms and conditions set forth in this Agreement, including all attachments and addenda, including the Request for Qualifications and Proposal, which are appended hereto by mutual agreement of the parties; and

WHEREAS, in procuring these services, City issued **RFQ/RFP No. 2023-01** seeking a qualified Broker/Consultant to provide Employee Benefits Insurance Brokerage and Consultation Services; and

NOW, THEREFORE, City agrees to retain and does hereby retain Broker/Consultant and Broker/Consultant agrees to provide the services required according to the terms and conditions and for the consideration hereinafter set forth:

1. **CONSULTANT'S DUTIES:** Consultant agrees to perform the following professional services as described in Exhibit B which is incorporated into this Contract by this reference. City shall furnish the Consultant with all data, information and other support for the scope of work described in Exhibit B.
2. **KEY PERSONNEL**
It is essential that the Consultant provide adequate experienced personnel, capable of and devoted to the successful accomplishment of work to be performed under this contract. The Consultant must agree to assign specific individuals to the key positions. The Consultant agrees that, once assigned to work under this contract, key personnel shall not be removed or replaced without written notice to the City. If key personnel are not available for work under this contract for a continuous period exceeding thirty calendar days or are expected to devote substantially less effort to the work than initially anticipated, the Consultant shall immediately notify the City, and shall, subject to the concurrence of the City, replace such personnel with personnel of substantially equal ability and qualifications.
3. **COMPENSATION:** The negotiated fee process shall be utilized for this Contract. For services rendered under this Contract, the Consultant shall be paid in accordance with the negotiated fee schedule. Payment shall be made monthly on the basis The City shall make every effort to process payment for the purchase of materials or services within thirty (30) calendar days after receipt of materials or services and a correct invoice.
4. **TERM AND RENEWAL:** The term of the Contract shall commence upon the award of the Contract and shall remain in effect for a period of three (3) years, unless terminated, canceled, or extended as otherwise provided herein. The Consultant

agrees that the City shall have the right, at its sole option, to renew the contract for one (1) additional two-year period or portion thereof. In the event that the City exercises such rights, all terms, conditions and provisions of the original Contract shall remain the same and apply during the renewal period with the possible exception of price and minor scope additions and/or deletions.

5. **CONSULTANT'S STANDARD OF PERFORMANCE:** While performing the services, Consultant shall exercise the reasonable professional care and skill customarily exercised by reputable members of the broker/consultant profession and shall use reasonable diligence and best judgment while exercising its professional skill and expertise. Consultant shall be responsible for all errors and omissions Consultant commits in the performance of this Agreement that are a breach of this standard.
7. **CONFIDENTIALITY:** Consultant, and any subcontractors or individuals hired by Consultant to perform the services under this Contract, shall keep any information concerning City matters confidential and agree that they will not make any statement, give an interview or provide any information to any person, corporation or other entity, including without limitation any media source, in relation to the project or the services to be provided under this Agreement without the prior written consent of City. Consultant, and any subcontractors or individuals hired by Consultant, agree not to disclose to any other person or entity (unless required by law) any confidential information concerning City matters during and after this Contract.
8. **NOTICES:** All notices to the other party required under this Contract shall be in writing and sent by first class certified mail, postage prepaid, return receipt requested, addressed to the following personnel:

If to City: City of San Luis Employee Health Benefits Trust
 Attn: City Manager
 P.O. Box 1170
 San Luis, AZ 85349

If to Consultant: _____
 Attn: _____

9. **TERMINATION:**
- a. This Contract may be terminated at any time by mutual written consent.
 - b. The City may terminate this Contract with or without cause, upon giving the Consultant at least sixty (60) days' written notice to Consultant.
 - c. If this Contract is terminated, the City shall be liable only for payment under the payment provisions of this Contract for services rendered and accepted

material received by the City before the effective date of termination. In the event of such termination, Consultant shall deliver to City all work in any state of completion or incompleteness at the date of effective termination.

- d. The City reserves the right to cancel the whole or any part of this Contract due to failure of Consultant to carry out any term, promise, or condition of the Contract. The City will issue a written ten (10) day notice of default to Consultant for acting or failing to act as in any of the following:
- In the opinion of the City, Consultant provides personnel that do not meet the requirements of the contract;
 - In the opinion of the City, Consultant fails to perform adequately the stipulations, conditions or services/specifications required in this contract;
 - In the opinion of the City, Consultant attempts to impose on the City personnel or materials, products or workmanship, which is of an unacceptable quality.
 - Consultant fails to furnish the required service and/or product within the time stipulated in the contract;
 - In the opinion of the City, Consultant fails to make progress in the performance of the requirements of the contract and/or give the City a positive indication that Consultant will not or cannot perform to the requirements of the contract.
10. **SUBCONTRACTORS:** Consultant shall, within ten (10) days after the execution of this Contract and before awarding any subcontract, furnish City with a written list of proposed subcontractors (including addresses and contact information), if any, and shall not employ any that City may object to for any reason. The City shall not unreasonably withhold approval and shall notify the Consultant of the City's position within 15 days of receipt of the written list of proposed subcontractors. Consultant agrees that it is as fully responsible to City for the acts and omissions of its subcontractors and of persons either directly or indirectly employed by them as it is for the acts and omissions of persons directly employed by Consultant. Consultant is responsible for contract performance whether or not subcontractors are used. Nothing contained in the Contract shall create any contractual relations between any subcontractor and City.
11. **RECORDS:** Records of Consultant's labor, payroll, and other costs pertaining to this Agreement shall be kept on a generally recognized accounting basis and made available to City for inspection on request and at the city's expense. Broker/Consultant shall maintain records for a period of at least two (2) years after termination of this Agreement and shall make such records available during that retention period for examination or audit by City personnel during regular business hours.

12. INSURANCE-GENERAL:

- a. **Insurer Qualifications.** Without limiting any obligations or liabilities of the Consultant, the Consultant shall purchase and maintain, at its own expense, hereinafter stipulated minimum insurance with insurance companies duly authorized by the State of Arizona with an AM Best, Inc. rating of A- or above with policies and forms satisfactory to the City. Failure to maintain insurance as specified herein may result in termination of this Agreement at the City's option.
- b. **No Representation of Coverage Adequacy.** By requiring insurance herein, the City does not represent that coverage and limits will be adequate to protect the Consultant. The City reserves the right to review any and all of the insurance policies and/or endorsements cited in this Agreement but have no obligation to do so. Failure to demand such evidence of full compliance with the insurance requirements set forth in this Agreement or failure to identify any insurance deficiency shall not relieve the Consultant from, nor be construed or deemed a waiver of, its obligation to maintain the required insurance at all times during the performance of this Agreement.
- c. **Additional Insured.** All insurance coverage and self-insured retention or deductible portions, except Workers' Compensation/Employer's Liability insurance and Professional Liability insurance, if applicable, shall name, to the fullest extent permitted by law for claims arising out of the performance of this Contract, the City, its agents, representatives, officers, directors, officials and employees as Additional Insured as specified under the respective coverage sections of this Contract.
- d. **Coverage Term.** All insurance required herein shall be maintained in full force and effect until all work or services required to be performed under the terms of this Contract are satisfactorily performed, completed and formally accepted by the City, unless specified otherwise in this Agreement.
- e. **Primary Insurance.** The Consultant's insurance, except Workers' Compensation/Employer's Liability insurance and Professional Liability insurance, if applicable, shall be primary insurance with respect to performance of this Contract and in the protection of the City as an Additional Insured.
- f. **Claims Made.** In the event any insurance policies required by this Agreement are written on a "claims made" basis, coverage shall extend, either by keeping coverage in force or purchasing an extended reporting option, for three (3) years past completion and acceptance of the services. Such continuing coverage shall be evidenced by submission of annual Certificates of Insurance and endorsements citing applicable coverage is in force and contains the provisions as required herein for the three-year period.
- g. **Waiver.** All policies, except for Professional Liability, including Workers' Compensation insurance, shall contain a waiver of rights of recovery (subrogation) against the City of San Luis or the City of San Luis Employee Benefits Trust, its agents, representatives, elected officials, officers and employees for any claims

arising out of the work or services of the Consultant. The Consultant shall arrange to have such subrogation waivers incorporated into each policy via formal written endorsement thereto on a blanket basis.

- h. **Policy Deductibles and/or Self-Insured Retentions.** The policies set forth in these requirements may provide coverage that contains deductibles or self-insured retention amounts. Such deductibles or self-insured retention shall not be applicable with respect to the policy limits provided to the City. The Consultant shall be solely responsible for any such deductible or self-insured retention amount.
- i. **Use of Subcontractors.** If any work under this Agreement is subcontracted in any way, the Consultant shall execute written agreement with the Subcontractor containing the indemnification provisions and insurance requirements (unless waived by City in the City's sole discretion) set forth herein protecting the City and the Consultant. The Consultant shall be responsible for executing the agreement with the Subcontractor and obtaining certificates of insurance verifying the insurance requirements.
- j. **Evidence of Insurance.** Prior to commencing any work or services under this Contract, the Consultant shall furnish the City with certificate(s) of insurance, and formal endorsements as required by this Contract, issued by the Consultant's insurer(s) as evidence that policies are placed with acceptable insurers as specified herein and provide the required coverages, conditions and limits of coverage specified in this Contract and that such coverage and provisions are in full force and effect. If a certificate of insurance is submitted as verification of coverage, the City shall reasonably rely upon the certificate of insurance as evidence of coverage, but such acceptance and reliance shall not waive or alter in any way the insurance requirements or obligations of this Agreement. If any of the above-cited policies expire during the life of this Agreement, it shall be the Broker/Consultant's responsibility to forward renewal certificates within ten (10) days after the renewal date containing all the aforementioned insurance provisions. Certificates of insurance shall specifically include the following provisions:
 - (1) The City, its agents, representatives, officers, directors, elected officials, Employee Benefits Trustees and employees are Additional Insureds for Consultant's Commercial General Liability Insurance.
 - (2) The Broker/Consultant 's insurance shall be primary and non-contributory insurance as respects performance of the Agreement, except Workers' Compensation/Employer's Liability insurance and Professional Liability insurance.
 - (3) All policies, excluding Professional Liability, waive rights of recovery (subrogation) against the City, its agents, representatives, officers, officials and employees for any claims arising out of work or services performed by the Consultant under this Contract.

- (4) A 30-day advance notice cancellation provision. If ACORD certificate of insurance form is used, the phrases in the cancellation provision "endeavor to" and "but failure to mail such notice shall impose no obligation or liability of any kind upon the company, its agents or representatives" shall be deleted. Certificate forms other than ACORD form shall have similar restrictive language deleted.

13. REQUIRED INSURANCE COVERAGE

- a. Commercial General Liability. The Broker/Consultant shall maintain "occurrence" form Commercial General Liability insurance with an unimpaired limit of not less than \$1,000,000 for each occurrence, \$1,000,000 Products and Completed Operations Annual Aggregate and a \$2,000,000 General Aggregate Limit. Such limits may be met in combination of primary and excess policies. The policy shall cover liability arising from premises, operations, independent contractors, products-completed operations, bodily injury or death, personal injury, advertising injury and property damage. Coverage under the policy will be at least as broad as ISO policy forms CG 00 010 or equivalent thereof, including but not limited to, separation of insured's clause. To the fullest extent allowed by law, for claims arising out of the performance of this Agreement, the City, its agents, representatives, officers, officials, volunteers and employees shall be cited as an Additional Insured under ISO, Commercial General Liability Additional Insured Endorsement form CG 20 10, or equivalent, which shall read "Who is an Insured (Section II) is amended to include as an insured the person or organization shown in the Schedule, but only with respect to liability arising out of "your work" for that insured by or for you."
- b. Vehicle Liability. The Broker/Consultant shall obtain Mexican insurance on any vehicle used to travel to Mexico in performance of this Contract with a minimum limit of \$1,000,000 each occurrence on the Consultant's owned, hired and non-owned vehicles assigned to or used in the performance of the Broker/Consultant's work or services under this Contract.
- c. Professional Liability (Errors and Omissions Liability). Broker/Consultant shall maintain Professional Liability insurance covering negligent errors and omissions arising out of the Services performed by the Consultant, or anyone employed by the Consultant, or anyone for whose negligent acts, mistakes, errors and omissions the Consultant is legally liable, with an unimpaired liability insurance limit of \$5,000,000 each claim and \$5,000,000 all claims. In the event the Professional Liability insurance policy is written on a "claims made" basis, Broker/Consultant warrants that any retroactive date under the policy shall precede the effective date of this Agreement; and that either continuous coverage will be maintained or an extended discovery period will be exercised for a period of three (3) years beginning at the time work under this Contract is completed.
- d. Workers' Compensation Insurance. Broker/Consultant shall maintain Workers' Compensation insurance to cover obligations imposed by federal and state statutes having jurisdiction of Consultant's employees engaged in the

performance of work or services under this Agreement and shall also maintain Employers Liability Insurance of not less than \$500,000 for each accident, \$500,000 disease for each employee and \$1,000,000 disease policy limit.

14. **CANCELLATION AND EXPIRATION NOTICE:** Insurance required herein shall not expire or be canceled without thirty (30) days prior written notice to the City.
15. **RIGHT OF CITY TO CONTRACT WITH OTHERS:** Nothing in this Agreement shall imply City is obligated to obtain the services described herein with only the Consultant.
16. **UNCONTROLLABLE FORCES / FORCE MAJEURE:** City and Broker/Consultant shall exert all efforts to perform their respective responsibilities under this Contract. However, neither party shall hold the other party responsible for inability to render timely performance if such inability is a direct result of a force beyond its control, including but not limited to the following: strikes, lockouts, embargoes, failure of carriers, inability to obtain transportation facilities, acts of God or the public enemy, or other events beyond the control of the other or the other's employees and agents.
17. **INDEMNIFICATION:** To the fullest extent allowed by law, Consultant shall defend, indemnify, and hold City, its officers, elected official, trustees, and employees harmless from any and all loss, damage, claim for damage, liability, expense, or cost, including reasonable attorneys' fees, which arise out of, or is in any way connected with the performance of work under this Contract by Consultant, or any of Consultant's employees, agents or subcontractors, and from all claims by Consultant's employees, subcontractors and agents for compensation for services rendered to Consultant in the performance of this Contract, notwithstanding that City may have benefited from their services. This indemnification provision shall only apply to any and all negligent acts or omissions, willful misconduct or negligent conduct, whether active or passive, on the part of Consultant or Consultant's employees, subcontractors or agents. This section shall survive the expiration or early termination of the Contract. The Consultant's obligation under this section shall not extend to any liability caused by the sole negligence of the City or its employees.
18. **WAIVER OF TERMS AND CONDITIONS:** The failure of City or Consultant to insist in any one or more instances on performance of any of the terms or conditions of this Contract or to exercise any right or privilege contained herein shall not be considered as thereafter waiving such terms, conditions, rights or privileges, and they shall remain in full force and effect. **INDEMNIFICATION:** Consultant shall indemnify, defend, and hold harmless the City, from any and all claims, demands, suits, actions, proceedings, loss, cost, and damages of every kind and description, including any reasonable attorney's fees and/or litigation expenses, which may be brought or made against or of any person, caused by, arising out of, or contributed to, in part, by reasons of any act, omission, professional error, fault, mistake, or negligence of the Consultant, its employees, agent, representatives, or

subcontractors, their employees, agents, or representatives in connection with or incidental to the performance of this Agreement, or arising out of Worker's Compensation Claims, unemployment compensation claims, or unemployment disability compensation claims of employees of the Consultant and/or its subcontractors or claims under similar such laws or obligations.

19. **INDEPENDENT CONTRACTOR:** Consultant shall at all times during Consultant's performance of the services retain Consultant's status as independent contractor. Consultant's employees shall under no circumstances be considered or held to be employees or agents of City, and City shall have no obligation to pay or withhold state or federal taxes or provide workers' compensation or unemployment insurance for or on behalf of them or the Consultant. It is clearly understood that each party shall act in its individual capacity and not as an agent, employee, partner, joint venture, or associate of the other. The City and the Consultant intend that an independent contractor relationship and not an employer-employee relationship is created by this Contract. The City is interested only in the results to be achieved, and not the conduct and control of the performance of the services contemplated in this Contract. The Consultant's rights include but are not limited to control of the work, manner and methods of the work, and the right to contract with other entities. The City's rights include but are not limited to inspection and approval of the work and the right to contract with others to perform the work. An employee or agent of one party shall not be deemed or construed to be the employee or agent of the other party for any purpose whatsoever. Consultant shall not be entitled to any City employee benefits and shall not be compensated in the form of salaries, or to paid vacation or sick days by the City, and that such days do not accumulate for the use of same at a later date.
20. **ARBITRATION.** It is understood and agreed that no provision of the contract relating to arbitration or requiring arbitration shall apply to or be binding upon the City except by the City's express written consent given subsequent to the execution of the contract. However, at the City's sole option, or by other means expressly approved by the City, disputes may be resolved through arbitration. The dispute shall be resolved as provided for in A.R.S. Sec. 12-1501, et seq. Consultant shall continue to render the services required by this contract without interruption, notwithstanding the provisions of this section.
21. **GOVERNING LAW AND VENUE:** The terms and conditions of this Agreement shall be governed by and interpreted in accordance with the laws of the State of Arizona. Any action at law or in equity brought by either party for the purpose of enforcing a right or rights provided for in this Agreement, shall be tried in a court of competent jurisdiction in Yuma County, State of Arizona. The parties hereby waive all provisions of law providing for a change of venue in such proceeding to any other county. In the event either party shall bring suit to enforce any term of this Contract or to recover any damages for and on account of the breach of any term or condition in this Contract, it is mutually agreed that the prevailing party in such action shall recover all costs including: all litigation and appeal expenses, collection expenses, reasonable attorneys' fees, necessary witness fees, expert fees, and court costs to be determined by the court in such action.

22. **OWNERSHIP OF RECORDS AND REPORTS:** All of the files, reports, documents, information and data prepared or assembled by Consultant under this Contract shall be and remain the property of City and shall be forwarded to City at any time City requires such papers. They shall not be used or released by the Consultant or any other person except with prior written permission by the City.
23. **LICENSE:** Broker/Consultant represents and warrants that any license necessary to perform the work under this Agreement is current and valid. Broker/Consultant understands that the activity described herein may constitute “doing business in the “City of San Luis” and Broker/Consultant agrees to obtain any necessary business license pursuant to San Luis City Code Chapter 5.05. and keep such license current during the term of this Contract. Any activity by subcontractors within the corporate city limits, will invoke the same business license regulations on any subcontractors, and Consultant ensures its subcontractors will obtain any required business license.
24. **NON-ASSIGNMENT:** This Contract has been entered into based upon the personal reputation, expertise and qualifications of the Consultant. Neither party to this Contract shall assign its interest in the Contract, either in whole or in part. Consultant shall not assign any monies due or to become due to it hereunder without the prior written consent of City. No delegation of any duty of the Consultant shall be made without prior written permission of the City.
25. **THIRD PARTY BENEFICIARIES:** There are no third-party beneficiaries of this Contract.
26. **ENTIRE AGREEMENT:** This Contract and its exhibits and attachments represent the entire agreement between City and Consultant and supersede all prior negotiations, representations or agreements, either express or implied, written or oral. It is mutually understood and agreed that no alteration or variation of the terms and conditions of this Contract shall be valid unless made in writing and signed by the parties hereto. Written and signed amendments shall automatically become part of the Contract, and shall supersede any inconsistent provision therein; provided, however, that any apparent inconsistency shall be resolved, if possible, by construing the provisions as mutually complementary and supplementary. This Contract is intended by the parties as a final expression of their agreement and is intended also as a complete and exclusive statement of the terms of this agreement. No course of prior dealings between the parties and no usage of the trade shall be relevant to supplement or explain any term used in this Contract. Acceptance or acquiescence in a course of performance rendered under this Contract shall not be relevant to determine the meaning of this Contract even though the accepting or acquiescing party has knowledge of the nature of the performance and opportunity to object.
27. **SEVERABILITY:** If any part, term or provision of this Agreement shall be held illegal, unenforceable or in conflict with any law by a court of competent jurisdiction or controlling legislation, the validity of the remaining portions and provisions hereof shall not be affected.

28. **CONFLICTS OF INTEREST:** The City may cancel this contract without penalty or further obligation pursuant to A.R.S. Section 38-511 if any person significantly involved in initiating, negotiating, securing, drafting, or creating the contract, on behalf of the City is or becomes, at any time while the contract or any extension of the contract is in effect, an employee of, or a contractor to any other party to this contract with respect to the subject matter of the contract. Such cancellation shall be effective when written notice from the Finance Department is received by the parties to this contract, unless the notice specifies a later time.
29. **IMMIGRATION:** To the extent applicable under ARIZONA REVISED STATUTE SECTION §41-4401, the Consultant and its subcontractors warrant compliance with all federal immigration laws and regulations that relate to their employees and compliance with the E-Verify requirements under A.R.S. § 23-214 (A).
- a. The Consultant or subcontractor's breach of the above-mentioned warranty shall be deemed a material breach of the Agreement and may result in the termination of the Agreement by the City of San Luis.
 - b. The City of San Luis retains the legal right to randomly inspect the papers and records of the Consultant and its subcontractors who work on the contracts ensure that the Consultant and its subcontractors are complying with the above-mentioned warranty.
30. **ISRAEL BOYCOTT:** To the extent permitted by law, Consultant certifies that it does not participate in and agrees not to participate during the term of this Contract a boycott of Israel in accordance with A.R.S. §35-393.01.
31. **FORCED LABOR:** Under A.R.S. § 35-394, the Consultant certifies that the Consultant is not currently engaged in and agrees for the duration of the contract it will not use the forced labor of ethnic Uyghurs in the People's Republic of China, any of their goods or services, or use any subcontractors or supplies that use their forced labor.
32. **CONTRACT AMENDMENTS:** This contract shall be modified only by a written contract amendment signed by the City of San Luis Employees Benefit Trust and persons duly authorized to enter into contracts on behalf of the Consultant.
33. **PROVISIONS REQUIRED BY LAW:** Each and every provision of law and any clause required by law to be in the contract shall be read and enforced as though it were included herein, and if through mistake or otherwise any such provision is not inserted, or is not correctly inserted, then upon the application of either party the contract shall forthwith be physically amended to make such insertion or correction.

IN WITNESS WHEREOF, the parties have caused this Agreement to be signed by their duly authorized representatives as of the day and year first above written.

CONSULTANT: _____

By: _____

Its: _____

CITY OF SAN LUIS EMPLOYEE BENEFITS TRUST

Tadeo Azael De La Hoya
Board of Trustees Chair

ATTEST:

Sonia Cornelio
City Clerk

APPROVED AS TO FORM:

City Attorney

EXHIBIT D – COMPLETED SUBSTITUTE W-9

Form W-9 (Rev. October 2018) Department of the Treasury Internal Revenue Service	Request for Taxpayer Identification Number and Certification Go to www.irs.gov/FormW9 for instructions and the latest information.	Give Form to the requester. Do not send to the IRS.																																													
1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank. CITY OF SAN LUIS																																															
2 Business name/disregarded entity name, if different from above																																															
3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes. ☐ Individual sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate ☐ Limited liability company. Enter the tax classification (C= C corporation, S= S corporation, LP= Partnership) LP <i>Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.</i> ☒ Other (see instructions) GOVERNMENT/MUNICIPALITY																																															
4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3) Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ <i>(Applies to accounts originated outside the U.S.)</i>																																															
5 Address (number, street, and apt. or suite no.) See instructions. PO BOX 7746 6 City, state, and ZIP code. SAN LUIS, AZ 85349		7 List account number(s) here (optional)																																													
Part I Taxpayer Identification Number (TIN) Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see <i>How to get a TIN</i>, later. <i>Note: If the account is in more than one name, see the instructions for line 1. Also see What Name and Number To Give the Requester for guidelines on whose number to enter.</i> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="9">Social security number</td> </tr> <tr> <td style="width: 25%;">[]</td> <td style="width: 25%;">[]</td> <td style="width: 25%;">[]</td> <td style="width: 25%;">[]</td> <td colspan="5"></td> </tr> <tr> <td colspan="9" style="text-align: center;">OR</td> </tr> <tr> <td colspan="9">Employer identification number</td> </tr> <tr> <td>[]</td> <td>[]</td> <td>[]</td> <td>[]</td> <td>[]</td> <td>[]</td> <td>[]</td> <td>[]</td> <td>[]</td> </tr> </table>			Social security number									[]	[]	[]	[]						OR									Employer identification number									[]	[]	[]	[]	[]	[]	[]	[]	[]
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Employer identification number																																															
[]	[]	[]	[]	[]	[]	[]	[]	[]																																							
Part II Certification Under penalties of perjury, I certify that: 1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and 3. I am a U.S. citizen or other U.S. person (defined below); and 4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct. Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.																																															
Sign Here Signature of U.S. person Date 02/14/2023																																															
General Instructions Section references are to the Internal Revenue Code unless otherwise noted. Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9. Purpose of Form An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following: - Form 1099-INT (interest earned or paid) - Form 1099-DIV (dividends, including those from stocks or mutual funds) - Form 1099-MISC (various types of income, prizes, awards, or gross proceeds) - Form 1099-B (stock or mutual fund sales and certain other transactions by brokers) - Form 1099-S (proceeds from real estate transactions) - Form 1099-K (merchant card and third party network transactions) - Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition) - Form 1099-C (canceled debt) - Form 1099-A (acquisition or abandonment of secured property) Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN. If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What Is backup withholding, later.																																															

EXHIBIT E – CONFLICT OF INTEREST DISCLOSURE



VENDOR CONFLICT OF INTEREST DISCLOSURE

INSTRUCTIONS

Vendors shall not try to gain an unfair competitive advantage or influence the ability of (City of San Luis) COSL employees to make impartial and objective decisions on behalf of COSL.

All vendors interested in conducting business with COSL must complete and return the Vendor Conflict of Interest Disclosure Form found on the following page in order to be eligible to be awarded a contract with COSL. Please note that all vendors are subject to comply with COSL's conflict of interest policies provided below.

1. No COSL employees (e.g., elected City official) or employee has an ownership interest of more than 5% in vendor's company.
2. No COSL employee is an officer, director, partner or proprietor of vendor's company.
3. No COSL employee is employed by or being considered for employment by vendor's company.
4. No COSL employee work as a consultant or has a contractual relationship with vendor's company.
5. No COSL employee will derive a personal financial gain or loss from this contract.
6. No relative of a COSL employee will derive a personal financial gain or loss from this contract. (Relatives include a father, mother, son, daughter, husband, wife, brother, sister, father-in-law, mother-in-law, son-in-law, or daughter-in-law.)

If a vendor has one or more relationships with a COSL employee or a relative of a COSL employee that meets the criteria described above, then the vendor shall disclose the information by completing the Conflict of Interest Form on the following page.



VENDOR CONFLICT OF INTEREST DISCLOSURE FORM

Disclosing a potential conflict of interest does not disqualify vendors. In the event vendors do not disclose potential conflicts of interest, and they are detected by ("City of San Luis") COSL vendor may be disqualified from doing business with COSL.

Bid/Solicitation/Contract Number:	Name of COSL Employee(s) Working on Vendor's Current Contract(s) with COSL:	
Vendor's Name:		Vendor's Phone:
Vendor's Authorized Representative Name and Title:		Authorized Representative's Phone:
NAME(S) OF COSL EMPLOYEE(S) WITH POTENTIAL CONFLICT OF INTEREST		
Name of COSL employee(s), or relative with whom there may be a potential conflict of interest. If more than five, attach a second form.	Relationship of COSL employee(s) and/or relative(s) to vendor's company from list above (e.g. 1(a), 2, etc.). Please list all that apply.	
1.		
2.		
3.		
4.		
☐ Vendor has no conflict of interest to report. ☐ Vendor hereby declares it has not and will not provide gifts or hospitality of any dollar value or any other gratuities to any COSL employee to obtain or maintain a contract. ☐ I certify that this Conflict of Interest Disclosure has been examined by me and that its contents are true and correct to my knowledge and belief and I have the authority to so certify on behalf of the Vendor.		
Vendor's Authorized Representative's Signature:		Date:

For COSL Only if Conflict Noted

Name of COSL Employee:	Signature:	Date:
Note:		



SECTION 1

KEY PERSONNEL BIOGRAPHIES

CBIZ EMPLOYEE BENEFITS

BUSINESS EXPERIENCE



Oscar A. Diaz

*Vice President of
Business
Development/
Consultant*



520.235.4726



odiaz@cbiz.com

Oscar Diaz is Vice President of Business Development and a Consultant and is responsible for providing consultative employee benefits service to some of the firm's largest clients. Oscar has been with CBIZ since 1998 and has been in the employee benefits consulting business since 1989. Oscar has an extensive background in providing consulting service to large employers.

Immediately prior to joining CBIZ Gordon, Zucarelli & Handley Business & Insurance Services (now CBIZ), Oscar served as BlueCross BlueShield of Arizona's (BCBSAZ) Major Account Manager for southern Arizona where he was responsible for providing account service to BCBSAZ's large group clients including both public and private sector clients. Some of Oscar's current clients include, Pima County Government, Town of Oro Valley, Northwest Fire District and Eastern Arizona College. During his career, Oscar has also worked other notable employers including CODAC, Community Partnership of Southern Arizona and Southern Arizona Mental Health Center.

Oscar also spent time as the Director of Account Service for NYLCare Health Plan of the Gulf Coast in Houston, Texas. At the time, NYLCare was Texas's largest managed healthcare. Insurance company. While with NYLCare, Mr. Diaz's department oversaw the servicing of more than 200 accounts with more than 250,000 members.

Oscar began his career with Intergroup of Arizona, the state of Arizona's 2nd largest HMO as their Director of Account Service for a period of seven years. In this position, Oscar oversaw a department that was responsible for providing service to over 1,000 accounts with over 100,000 members.

BACKGROUND

Education

Attended the University of Arizona and Studied Media Communications

Professional Designations

Health Insurance Association of America Designation (HIA)

Community Service Involvement

- Past Board Member & Treasurer - Tucson Hispanic Chamber of Commerce
- Past Board Member - Southern Arizona Arts and Cultural Alliance
- Past Community Leadership Board Member - American Diabetes Association
- Past Board Chair and Board Member - CODAC Behavioral Health
- Past Board Member - Chicanos Por La Causa
- Past Classroom Volunteer - Junior Achievement



CBIZ EMPLOYEE BENEFITS



Jennifer Aragon

Mid-Market Account Executive, Tucson



520.321.7547



jaragon@cbiz.com

BUSINESS EXPERIENCE

Jennifer joined CBIZ Benefits & Insurance Services as an Account Executive in November 2012. She is primarily responsible for providing consultative health, dental, vision, disability and life insurance account services for mid-market size client groups ranging in size from 30 to 300 employees. Jennifer has extensive knowledge and expertise in fully insured, level funded and self-funded medical, dental, life and disability employer sponsored welfare benefit plans. She also has knowledge of wellness programs, EAP's, voluntary benefits, COBRA, Section 125 plans (Flexible Spending Accounts), Health Savings Accounts (HSA), Health Reimbursement Accounts (HRA) and the Affordable Care Act employer requirements. Jennifer works diligently with the CBIZ Benefits Team to ensure her clients experience exceptional customer service.

Jennifer works with several of our public sector clients and has worked with a variety of governmental and public school districts during her professional benefits consulting career.

Jennifer brings over 20 years of employee benefits experience to her position and offers this knowledge and perspective to our team and clients. Prior to CBIZ, she served as an Account Manager with another brokerage in Tucson, AZ specializing in employer groups from 2 to 500. She worked directly with carrier partners, employers, and employees assisting with day-to-day service.

Jennifer holds a Life, Health and Accident license in the State of Arizona and frequently attends seminars regarding healthcare trends, compliance, COBRA, HIPAA, and other areas affecting employer benefits.

BACKGROUND

Education

- Bachelor's Degree in Business Management from Eastern New Mexico
- Associate's Degree in Liberal Arts from Pima Community College
- Human Resources Certificate from Pima Community College

Professional Designation

- Arizona Life, Health and Accident Insurance License



CBIZ EMPLOYEE BENEFITS



Debbie Jamison

*Account Manager,
Tucson*



520.321.7513



djamison@cbiz.com

BUSINESS EXPERIENCE

Debbie brings over 24 years of health insurance experience to her position at CBIZ and offers this knowledge and perspective to our team and our clients. She is well versed in fully insured and self-insured medical plans, consumer driven health plan arrangements (HRAs and HSAs), dental, vision, life, disability, EAPs, and wellness programs. Debbie works with several of our public sector clients and has worked with a variety of governmental and public school districts during her professional benefits consulting career.

Before joining CBIZ, Debbie was employed on the carrier side of the business. Her primary focus was conducting employee education in both English and Spanish.

BACKGROUND

Education

Debbie has a Bachelor's Degree from the University of Arizona. She frequently attends seminars regarding healthcare reform & trends, compliance, COBRA, HIPAA and other areas affecting employer benefits. She holds insurance licenses in multiple states.



CBIZ EMPLOYEE BENEFITS

BUSINESS EXPERIENCE

In 1999 Cameron joined CBIZ Benefits & Insurance Services, Inc. and began the process of designing and developing presentations and comprehensive spreadsheets for clients. Cameron has since been promoted to CBIZ's Analyst position. As the Analyst, Cameron works closely with insurance carriers, third party administrators and reinsurance carriers to develop customized client claim reports and to review claim costs, trends and patterns.

Cameron provides analytic support to all of CBIZ self-funded, public sector and governmental clients.

Cameron's career began in the insurance industry with Health Net of Arizona in 1992, formally Intergru of Arizona, Inc., as a customer service representative and as an Independent Physician Associate (IPA) Specialist. Cameron was responsible for assisting members with benefit questions, solving claim issues and assisting with enrollment. As an IPA Specialist Cameron assisted IPA physician offices with benefits, referrals, and claim and contract issues.

BACKGROUND

Professional Designations

- Arizona Health and Life Insurance License
- Microsoft Excel Certification



Cameron Dugan

Analyst, Tucson



520.321.7528



cdugan@cbiz.com



CBIZ EMPLOYEE BENEFITS



Anisa Karczynski

*Wellbeing &
Engagement Account
Executive, Tucson*



520.321.7516



anisa.karczynski@cbiz.com

BUSINESS EXPERIENCE

Anisa Karczynski, MPH, serves as a Wellbeing and Engagement Account Executive with CBIZ, a national leader in developing and implementing health and productivity strategies. She holds a masters' degree in Public Health, with a specialization in employee wellbeing and safety program strategies and development.

In her role at CBIZ, Anisa works to develop and implement evidence-based strategies to build and maintain a culture of total wellbeing based on client needs. Anisa works collaboratively with clients and wellbeing vendor partners to develop and deliver effective and sustainable solutions with the goal of helping individuals and companies thrive.

Prior to CBIZ, Anisa worked as an employee wellness program manager. She developed, implemented, and enhanced employee wellness programs with employers throughout Tucson, Arizona. Anisa brings over eight years of employee wellbeing solutions experience to her position and prides herself on staying current on product knowledge and the constantly evolving world of employee wellbeing and engagement.

Anisa works with several of our public sector clients and has worked with a variety of governmental and public school districts during her professional benefits consulting career.

BACKGROUND

Education

- Master of Public Health, Health Promotion – University of Arizona
- Bachelor of Science, Commerce – University of Arizona

Service Specialties

- Strategic Planning
- Wellbeing & Culture Needs
- Assessments Program & Incentive Design
- Wellness Committee Development & Support
- Effective Communication Guidance





SECTION 2

REFERENCES &

**LIST OF CBIZ'S PUBLIC SECTOR
& GOVERNMENTAL CLIENTS**

CBIZ References



	Long-Term Clients
Client	Town of Oro Valley
Contact Name	Andrew Votava
Title	HR Director
Phone Number	520-229-4750
Email Address	avotava@orovalleyaz.gov
CBIZ Client Since	2008
# of Employees	314

Client	City of Nogales
Contact Name	Carmen Fuentes
Title	HR Director
Phone Number	520-285-5622
Email Address	crojas@nogalesaz.gov
CBIZ Client Since	2016
# of Employees	295

	Recent Clients
Client	Northwest Fire District
Contact Name	Kim Sotomayor
Title	Business Services Director
Phone Number	520-887-1010 ext. 2915
Email Address	ksotomayor@nwfdaz.gov
CBIZ Client Since	2022
# of Employees	280

Client	Eastern Arizona College
Contact Name	Lydia Newkirk
Title	Director of HR
Phone Number	928-428-8280
Email Address	lydia.newkirk@eac.edu
CBIZ Client Since	2022
# of Employees	285

CBIZ Public Sector Entity Clients



Governmental Agencies	CBIZ Client Since	Contact Name	Title	Phone Number
City of Bisbee	2009	Joelle Landers	Personnel Director	520-432-6271
City of Nogales	2016	Carmen Fuentes	Human Resources Director	520-287-6571
City of South Tucson	2001	Veronica Moreno	HR Director	520-792-2424 ext. 312
City of Surprise	2016	Donna Muese	Director of Human Resources	623-222-3529
City of Tombstone	2019	Charissa Prestley	Accounts Payable/HR	520-457-2202
Northwest Fire District	2022	Kim Sotomayor	Business Services Director	520-887-1010 ext. 2915
Pascua Yaqui Tribal Government	2006	Andrew Esposito	Director of Human Resources	520-883-5046
Picture Rocks Fire District	2003	Brett Lane	Office Manager	520-682-7878
Pima County Government	2004	Gayl Zambo	HR Manager	520-740-8006
Pinal County	2019	MaryEllen Sheppard	Deputy County Manager	520-509-3555
State of Arizona/Arizona Department of Administration	2018	Renee Uliassi	Statewide Procurement Manager	602-542-8087
Town of Oro Valley	2008	Andrew Votava	HR Director	520-229-4750
Town of Patagonia	2015	Isabel Van Nest	Deputy Clerk	520-394-2010
Town of Prescott Valley	2021	Terri Traaen	Director of Human Resources	928-759-3111
Public School Districts	CBIZ Client Since	Contact Name	Title	Phone Number
Baboquivari Unified School District	2008	Darolyn Mease	HR Specialist	520-719-1200 ext 1014
Patagonia Elementary School District	2003	Angelica Lucero	Business Manager	520-394-3052
Patagonia Union High School District	2003	Angelica Lucero	Business Manager	520-394-3052
Pima County School Superintendent		Leah Swisher	Unsure	520-724-8993
Santa Cruz Valley Unified School District	2003	Rebekah Cabrera	HR Director	520-375-8265
Santa Cruz Elementary School District	2003	Denisse Melendez	Business Mgr.	520-287-0737
Sunnyside Unified School District	2013	Amanda Schmich	HR Benefit Manager	520-545-2006
Tanque Verde School District	2003	Keith Wick	HR Manager	520-749-5751 x 4107
Vail School District	2003	Laura Emslie	Assistant Director of HR	520-879-3922
Community College	CBIZ Client Since	Contact Name	Title	Phone Number
Eastern Arizona College	2022	Lydia Newkirk	Director of HR	928-428-8280
Governmental Agencies	CBIZ Client Since	Contact Name	Title	Phone Number
Valley Wise Health	2021	Susan Lara-Willars	Chief Human Resources Officer	602-344-5011



SECTION 3

WORK SAMPLES



SECTION 3

EMPLOYEE COMMUNICATIONS DOCUMENTS SAMPLES

GUÍA DE BENEFICIOS PARA EMPLEADOS



2023-2024



BIENVENIDOS A SU COBERTURA

BIENVENIDOS A LA INSCRIPCIÓN ABIERTA DE BENEFICIOS DE 2023-2024

Este resumen es una breve guía del plan de beneficios de la Ciudad de Nogales. Ésta es su oportunidad de evaluar su plan de seguro médico y decidir si desea realizar algún cambio.

Debe tomar acción ahora si desea:

- ✓ Realizar algún cambio en su plan médico (se requieren documentos justificativos)
- ✓ Inscribirse o volver a inscribirse en un plan médico (se requieren documentos justificativos)
- ✓ Optar por no participar en su plan médico (una vez que cancela su plan, no podrá volver a inscribirse durante este año del plan (23-24) a menos que experimente un evento calificativo)

¿NINGÚN CAMBIO?

SU COBERTURA E ELECCIONES ACTUALES SE TRANSFERIRÁN AUTOMÁTICAMENTE AL PRÓXIMO AÑO (año fiscal 23-24)

ADEMÁS, RECUERDE:

- ✓ Actualizar su información de contacto personal
- ✓ Actualizar el formulario de nombramiento de beneficiario de seguro de vida
- ✓ Inscribirse con Virgin Pulse (programa de salud y bienestar)

Llame a Recursos Humanos al (520) 287-6571 para programar una cita

¡No habrá ningún cambio en las primas durante el próximo año del plan!

INFORMACIÓN IMPORTANTE SOBRE CAMBIOS AL PLAN

- Inicialmente, los empleados elegibles deberán inscribirse dentro del plazo de inscripción requerido.
- Después de la inscripción inicial, se pueden realizar cambios en el plan de beneficios una vez al año durante la inscripción abierta, a menos que experimente un evento calificativo.
- Cualquier cambio realizado durante la inscripción abierta entrará en vigencia el primero de julio de 2023.
- El año del plan para la cobertura es del primero de julio de 2023 hasta el 30 de junio de 2024.

TIP

¡RECUERDE! La inscripción abierta es la única época del año en la que puede realizar los ajustes que desee para el próximo año del plan.



¡Haga clic en este ícono "PLAY" en todo el libro para acceder a videos que detallan sus beneficios!

ELEGIBILIDAD E INSCRIPCIÓN

¿Cuándo comienzan mis beneficios?

El plan cubre los empleados elegibles el primer día del mes posterior a su fecha de contratación, siempre que presenten el formulario de inscripción correctamente completado al empleador. Se recomienda que se inscriba lo antes posible para garantizar la inscripción en el plan y para recibir su tarjeta de identificación antes de la fecha del comienzo de cobertura.

Si no se inscribe en el plan dentro de los 30 días posteriores al cumplimiento de los requisitos de elegibilidad, tendrá que esperar hasta la próxima inscripción abierta anual para inscribirse.

¿Quién se considera un dependiente elegible?

- Su cónyuge legal
- Hijos dependientes hasta los 26 años*
- Los hijos de los empleados: hijos naturales, adoptivos, hijastros
- Un niño para quien el empleado o su cónyuge tiene la tutela legal

***Los hijos dependientes están cubiertos por el plan hasta que el hijo cumpla 26 años, independientemente de su estado civil, residencia o condición de estudiante.**

¿Cómo agrego a mi cónyuge y/o hijo(s) dependiente(s) a mi plan de beneficios?

Puede agregar a sus dependientes elegibles cuando sea elegible por primera vez para la cobertura o durante cualquier período de inscripción abierta. Si inicialmente usted no inscribe a los miembros de su familia en el plan, ciertos eventos calificativos le permitirán inscribir a sus dependientes durante el año. Debe completar un formulario de inscripción y entregar la documentación correspondiente para realizar algún cambio a más tardar 30 días después del evento calificativo.

Los eventos calificados incluyen, entre otros:

- Cambio de estado civil (matrimonio, separación legal, divorcio o muerte de un cónyuge)
- Nacimiento, adopción, colocación para la adopción o muerte de un hijo dependiente
- Cambio en la situación laboral de su cónyuge
- Cambio en la elegibilidad para cobertura de su cónyuge

¿Cómo cancelo la cobertura, a través de mi plan, para mi cónyuge y/o hijo(s) dependiente(s)?

Solo se puede pedir la cancelación de la cobertura para sus dependientes durante la inscripción abierta o si hay un evento calificativo. El formulario de inscripción con el cambio debe recibirse por su empleador dentro de los 30 días posteriores a la fecha del evento calificativo.

Consulte el documento de su plan que se encuentra en línea en www.summit-inc.net o comuníquese con el Departamento de Servicio al Cliente de Summit al 1-888-690-2020.

Coordinación de beneficios

Si usted o sus dependientes tienen cobertura bajo este plan y otro plan, los dos planes pueden coordinar los beneficios. El plan que cubre al empleado es el plan principal del empleado. Para los hijos cubiertos por los planes de ambos padres, generalmente el padre que cumple años primero en el año será el pagador principal.

RECUERDE QUE...

Cualquier cambio de plan que desee realizar en relación con un evento calificativo debe solicitarse por escrito dentro de los 30 días posteriores de la fecha del evento calificativo, con verificación de dicho evento.



¿Qué es un evento calificativo?



COBERTURA MÉDICA

La Ciudad de Nogales ofrece cobertura para los empleados y sus dependientes con beneficios médicos, dentales y de la vista a través del Plan de Fideicomiso de Beneficios para Empleados de la Ciudad de Nogales. El plan es administrado por Summit Administrators. La Ciudad paga un porcentaje de la prima en función de los niveles salariales.

TIP

proveche al máximo su seguro utilizando proveedores dentro de la red.

PREGUNTAS FRECUENTES

? Me acaban de contratar. ¿Cuándo comienza mi cobertura?

Si es empleado de tiempo completo, su cobertura comienza el primer día del mes siguiente a su fecha de contratación.

? ¿El deducible se contabiliza por año calendario o año de la póliza?

En base al año calendario.

? ¿Por cuánto tiempo puedo cubrir a mis hijos dependientes?

Los hijos dependientes son elegibles hasta el final del mes en el que cumplen los 26 años.



Explicación de términos de beneficios



COBERTURA MÉDICA



COBERTURA DENTAL



COBERTURA DE LA VISTA

PLAN MÉDICO

DESCRIPCIÓN DE COBERTURA	DENTRO DE LA RED, EL MIEMBRO PAGA	FUERA DE LA RED, EL MIEMBRO PAGA
Deductible (cada año calendario)	\$500 Individual / \$1,200 Familiar (total)	\$1,000 Individual / \$2,500 Familiar (total)
Coaseguro (lo que paga el miembro)	20%	50%
Desembolso máximo Incluye el deducible, copagos y coaseguro	\$3,500 Individual / \$10,000 Familiar (total)	\$10,000 Individual / \$25,000 Familiar (total)
Atención preventiva	Cubierto al 100%	50%, sujeto al deducible
Cobertura máxima	Sin límite	
Equipo médico - se aplican límites	20%, sujeto al deducible	50%, sujeto al deducible
Servicios de emergencia/urgencia	DENTRO DE LA RED, EL MIEMBRO PAGA	
Ambulancia	20%, sujeto al deducible	
Sala de emergencias	20%, sujeto al deducible	
Atención de urgencias	Copago de \$35	
Servicios de atención médica en el hogar Se aplican límites	20%, sujeto al deducible	
Servicios de cuidados paliativos	20%, sujeto al deducible	
Servicios hospitalarios - se requiere precertificación		
Hospitalización	\$500 por hospitalización; deducible, luego 20%	
Centro de cirugía ambulatoria/para pacientes ambulatorios	20% después del deducible	
Laboratorio, radiografías, servicios diagnósticos	Copago de \$25	
Servicios diagnósticos especializados - se requiere precertificación (por ej. tomografías RM, TEP, TAC)	Copago de \$75	
Servicios de salud mental		
Hospitalización - se requiere precertificación	\$500 por hospitalización; deducible, luego 20%	
Servicios ambulatorios	20% después del deducible	
Consulta	Copago de \$25	
Servicios en consultorio médico - Enfermedades y lesiones		
Médico de atención primaria (PCP)	Copago de \$25 por consulta	
Médico especialista	Copago de \$25 por consulta	
Medicamentos recetados		
En farmacia - Suministro de 30 días	Antihistamínicos e inhibidores de la bomba de protones de venta libre: Copago de \$0 Anticonceptivos: Copago de \$0 Genérico: Copago de \$8 Marca preferida: \$40 de copago Marca no preferida: \$80 de copago Farmacia especializada: \$125 de copago	
Pedidos por correo - Suministro de 90 días	\$0 / \$20 / \$100 / \$100% pagado por el miembro	



Atención preventiva

COBERTURA DENTAL, DE LA VISTA Y INTERNATIONAL MEDICAL SOLUTIONS, INC. (IMS)



COBERTURA DENTAL

La cobertura dental es un porcentaje del monto usual y razonable para gastos dentales cubiertos incurridos, como se muestra en la lista de cobertura a continuación.

DESCRIPCIÓN DE COBERTURA	DENTRO DE LA RED
Beneficio máximo por año calendario	\$2,000 por persona
Deducible por año calendario	\$50 Individual / \$150 Familiar (total)
Servicios dentales diagnósticos, preventivos, básicos y principales	Cubierto al 80%
Prostodoncia de oro, incrustaciones inlay y onlay, puentes, coronas	Cubierto al 50%
Servicios de ortodoncia	Cubierto al 50% hasta un máximo de \$2,000 mientras esté asegurado por este plan



¿Qué es el seguro dental?



COBERTURA DE LA VISTA

Plan de la vista

El plan de la vista permite \$200 de cobertura por año, por cada miembro cubierto por el plan. Se proporciona un par de lentes de contacto, o un suministro anual de lentes de contacto desechables, en lugar de armazones y lentes.



IMS

International Medical Solutions, Inc. (IMS)

Este es un plan integral de servicios de atención médica que brinda atención médica de alta calidad para la creciente fuerza laboral en los EE. UU. cuya preferencia es recibir cobertura de atención médica en México. Tenga en cuenta que su participación en este programa es totalmente voluntaria. IMS se compromete a proporcionar atención médica de calidad y asequible en México.

Cómo usar los servicios médicos en México

1. El miembro y su dependiente (si corresponde) deben proporcionar su identificación válida con fotografía y su tarjeta de identificación médica de la Ciudad de Nogales al momento del servicio.
2. Los servicios se prestarán a los miembros y sus dependientes después de la verificación electrónica a través de Summit.
3. El miembro firmará un comprobante que muestre los servicios prestados (cirugías, análisis de laboratorio, imágenes médicas, etc.) al momento del servicio. (El miembro/paciente es responsable de los copagos y/o deducibles aplicables al momento del servicio.)
4. International Medical Solutions trabajará directamente con Summit para garantizar que se cumplan todos los requisitos de pago.
5. Summit pagará a International Medical Solutions a favor del plan por los servicios prestados en México.
6. International Medical Solutions supervisará y auditará todos los servicios prestados en México (preocupaciones y quejas de los miembros, etc.).



Explicación de términos de beneficios (ESPAÑOL)

SERVICIOS MÉDICOS EN MÉXICO



Beneficios médicos - Cobertura en México

DESCRIPCIÓN Y LÍMITES DE COBERTURA	EL MIEMBRO PAGA
El plan anual es del primero de enero al 31 de diciembre	El plan pagará al 100% de gastos cubiertos después del copago
Individual (por persona) Familiar (total)	Sin deducible máximo
Hospitalización para pacientes internados	Copago de \$50, luego el plan paga el 100%
Hospitalización para pacientes ambulatorios / Centro quirúrgico ambulatorio	Copago de \$5, luego el plan paga el 100%
Servicios de la sala de emergencia	Copago de \$50, luego el plan paga el 100%
Servicios del médico Visita al consultorio Cirugía - consultorio del médico Cirugía - internado	Copago de \$5, luego el plan paga el 100% Copago de \$5, luego el plan paga el 100% El plan paga el 100%
Patología Durante la visita al consultorio Otro	El plan paga el 100% Copago de \$5, luego el plan paga el 100%
Anestesiología	Copago de \$5, luego el plan paga el 100%
Radiología Durante la visita al consultorio Otro	El plan paga el 100% Copago de \$5, luego el plan paga el 100%
Atención preventiva	El plan paga el 100%
Centro de atención urgente	Copago de \$50, luego el plan paga el 100%

Beneficios dentales - Cobertura en México

Para los servicios prestados en México a través de un proveedor participante, el plan paga una tarifa negociada.

Para los servicios prestados en México a través de un proveedor no participante o fuera del plan, el plan pagará el 50 por ciento del monto usual. El plan realizará el pago del beneficio directamente al empleado.

DESCRIPCIÓN DE COBERTURA	DENTRO DE LA RED
Beneficio máximo por año calendario	\$2,000 por persona
Deducible por año calendario	\$50 individual / \$150 familiar (total)
Servicios dentales diagnósticos, preventivos, básicos y principales	Cubierto al 80%
Prostodoncia de oro, incrustaciones inlay y onlay, puentes, coronas	Cubierto al 50%
Servicios de ortodoncia	Cubierto al 50% hasta un máximo de \$2,000 mientras esté asegurado por este plan

Beneficios de medicamentos recetados - Cobertura en México

PUNTO DE COMPRA	EL MIEMBRO PAGA
SOLO proveedores de International Medical Solutions – suministro de 30 días	El plan paga el 100% después del copago: marca preferida: copago de \$10

PROGRAMA DE ASISTENCIA AL EMPLEADO, SEGURO DE VIDA, AD&D

Programa de Asistencia al Empleado (EAP)

La Ciudad de Nogales ahora ofrece un programa EAP completo y confidencial sin cargo para los empleados y sus familias inmediatas a través de SupportLinc. Los servicios están disponibles en cualquier momento del día o de la noche. Puede acceder a asistencia a través del teléfono, portal web, aplicación móvil, terapia de texto, recursos auto guiados. También hay acceso a consultas legales y financieras. Los problemas con los que SupportLinc puede ayudar incluyen:

- La ansiedad
- La depresión
- Dificultades matrimoniales y de relación
- Pérdida y duelo
- Abuso de sustancias
- Manejo de la ira
- Presiones relacionadas con el trabajo
- El estrés



Programas de asistencia al empleado

Seguro de vida por término grupal/Seguro de muerte y desmembramiento accidental

A través de Symetra Life Insurance Company, la Ciudad proporciona una póliza de seguro de vida de \$50,000 y un monto correspondiente de seguro de muerte y desmembramiento accidental para cada empleado calificado sin costo alguno al empleado. Esta cobertura entra en vigencia el primer día del mes siguiente a la fecha de contratación.

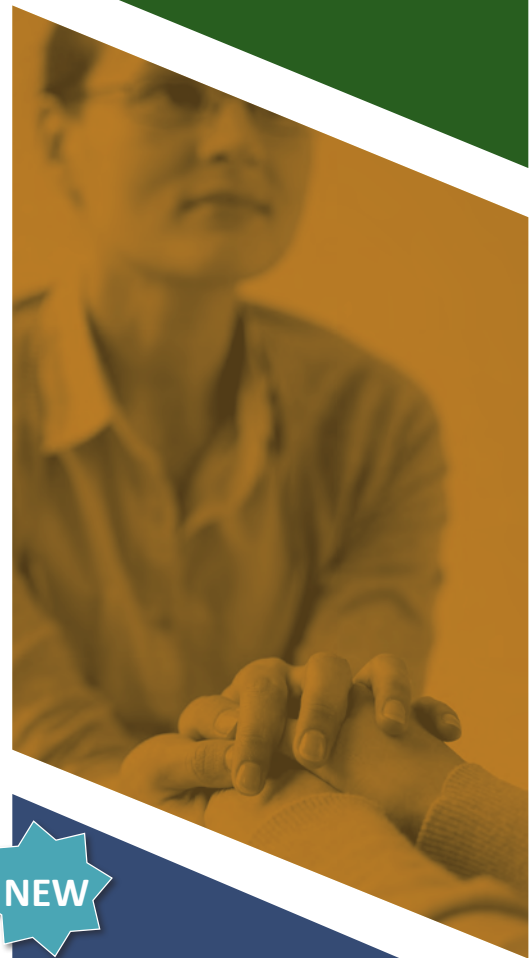
El seguro de vida suplementario está disponible para 1x, 2x o 3x la cantidad del seguro de vida básico. Tiene la opción de comprar cobertura adicional para su cónyuge y/o su(s) hijo(s). Se aplican ciertas restricciones. Póngase en contacto con Recursos Humanos para obtener más información.



Seguro de vida a término



BENEFICIOS ADICIONALES



NEW

Seguro por incapacidad a corto plazo

La ciudad brinda cobertura por incapacidad a corto plazo a partir del 1 de julio de 2023. Los empleados elegibles para el beneficio tendrán la cobertura de STD (excepto la policía y los bomberos)

La cobertura comienza 14 días después de la enfermedad o accidente

El beneficio semanal: el 60% de su salario semanal, sin exceder los \$1,500 por semana.

Plazo del beneficio: hasta 24 semanas
Comuníquese con Recursos Humanos para obtener más detalles

VIRGIN PULSE

Para mejorarse a sí mismo

Programa de Bienestar de la Ciudad de Nogales

El programa de bienestar de la Ciudad, brindado por Virgin Pulse, lo ayudará a realizar pequeños cambios en su bienestar cada día, con un enfoque en las cosas que más desea mejorar. Este programa es una experiencia de bienestar personalizada para ayudarlo a estar y mantenerse saludable. Recomendamos que participe cada día, en cualquier momento y en cualquier lugar que esté, para desarrollar hábitos saludables, divertirse con sus compañeros de trabajo y disfrutar las recompensas de por vida de una mejor salud y bienestar.

Gane 10,000 puntos antes del 30 de junio de 2024 para ganar \$250 en Pulse Cash, que se pueden usar para comprar equipo de entrenamiento, agendas y planificadores, dispositivos (Apple Watch, Fitbit, Beats, etc.), mantas pesadas, mochilas, anteojos y más en la tienda en línea de Virgin Pulse.

Los cónyuges que logren su meta de puntos antes del 31 de mayo de 2024 ayudarán a su cónyuge de la Ciudad de Nogales, ya que se le darán 1,500 puntos adicionales al total de los puntos del empleado.

CÓMO EMPEZAR:

- 1 Active su cuenta de Virgin Pulse.**
- 2 Descargue la aplicación móvil Virgin Pulse para iOS o Android.**
- 3 Conecte un monitor de actividad** para obtener crédito por las actividades de bienestar como sus pasos, minutos activos y tiempo dormido. Sincronizamos con muchos monitores, como Apple Watch, Fitbit, Garmin y MyFitnessPal, solo por nombrar algunos
- 4 Suba una foto de perfil y agregue algunos amigos.**
- 5 En la pestaña “Health”, haga clic en “Health Check” para realizar la evaluación.**



¡NO SE PIERDA TODA LA DIVERSIÓN!

¡DESCARGUE LA APLICACIÓN MÓVIL O VAYA A:

join.virginpulse.com/nogalesaz

PARA EMPEZAR!



Summit Administration Services, Inc.

Summit es el administrador externo (TPA, por sus siglas en inglés) del plan de salud de la Ciudad de Nogales. Los representantes de servicio al cliente de Summit están capacitados en sus beneficios específicos y pueden responder a cualquier pregunta relacionada con la elegibilidad, los beneficios, el pedido de tarjetas de identificación y los reclamos. No dude en llamarlos al 1-888-690-2020 durante el horario normal de atención. También puede acceder a sus reclamos y a la información del plan en línea al registrarse en el sitio web:

www.summit-inc.net

Plan médico/Medicamentos recetados

Summit es el administrador de reclamos del plan médico de la Ciudad de Nogales. La red de proveedores es BlueCross BlueShield de Arizona (BCBSAZ). Los empleados y sus dependientes cubiertos deben usar proveedores dentro de la red para recibir los beneficios y asegurarse de que paguen costos menores por cuenta propia. Los beneficios que se muestran en la tabla de la página 7 reflejan esos beneficios. Si sale de la red de BCBSAZ, pagará costos más altos.

Información del plan

¿Qué es una red PPO (Organización de Proveedores Preferidos)?

Una red PPO se compone de profesionales de atención médica que proporcionan una tarifa con descuento para sus servicios. A su vez, usted recibe mejores beneficios y paga menos de su propia cuenta. Consulte la lista de beneficios para comparar los beneficios dentro y fuera de la red.

¿Qué es una precertificación/autorización previa?

Ciertos servicios requieren precertificación/autorización previa. La precertificación/autorización previa se refiere al proceso de determinar si los servicios son médicamente necesarios. La falta de cumplir con este paso dará lugar a que se reduzca el coaseguro del plan en un 10%.

Los siguientes servicios REQUIEREN precertificación/autorización previa:

- Hospitalización para pacientes internados, incluyendo la salud mental/abuso de sustancias
- Cirugía ambulatoria
- Las resonancias y tomografías RM, TAC y TEP

Para obtener una lista detallada, consulte el documento de su plan en línea en www.summit-inc.net o comuníquese con el departamento de servicio al cliente de Summit al 1-888-690-2020.

Si tiene preguntas adicionales, comuníquese con:
SUMMIT
P.O. Box 25160
Scottsdale, AZ 85255
Teléfono: 1-888-690-2020
www.summit-inc.net

Cómo obtener acceso en línea

Si está cubierto por el plan médico, puede acceder su cuenta en línea en:

www.summit-inc.net

Una vez en el sitio web, haga clic en "Client Access", luego en "Sign-up", llene el formulario de registro, y cree su nombre de usuario y contraseña. Una vez registrado, solo necesitará ingresar su nombre de usuario y contraseña.

El acceso en línea le permite:

- Ver la información de su cuenta (dirección, fecha de nacimiento, fecha de vigencia de cobertura)
- Verificar la inscripción de dependientes
- Revisar la cobertura de beneficios
- Obtener respuestas a preguntas frecuentes (FAQ, por sus siglas en inglés)
- Verificar el estado de un reclamo
- Solicitar una tarjeta de identificación
- Ponerse en contacto con el servicio al cliente en línea

Medline Plus ofrece información confiable y actualizada sobre la salud, medicamentos recetados y suplementos, en cualquier momento y lugar, de forma gratuita.

La reforma del sistema de salud exige que cada empleador que patrocina un plan de salud grupal proporcione a cada empleado un Resumen de Beneficios y Cobertura durante el período de inscripción abierta, y cuando sea contratado por primera vez y sea elegible para inscribirse. Para ver o imprimir una copia, visite a www.summit-inc.net.



Aplicación móvil de Summit

Summit ahora ofrece soluciones móviles que le brindan las herramientas y recursos para tener acceso a su información de beneficios de atención médica. La aplicación Summit Admin le brinda la posibilidad de ver el estado de su reclamo e historial de reclamos, comunicarse con el servicio al cliente, ver sus tarjetas de identificación y otra información de elegibilidad.

¡Busca "Summit Admin" para descargar la aplicación y comenzar hoy mismo!

Disponible en iTunes App Store o Google Play Store.

CONTACTOS Y RECURSOS

CONTACTOS		
El Departamento de Recursos Humanos de la Ciudad de Nogales Carmen Fuentes Ana De la Ossa Danielle Zuñiga	520.287.6571	crojas@nogalesaz.gov agdelaossa@nogalesaz.gov dzuniga@nogalesaz.gov
Administración de reclamos médicos, dentales y de la vista/Preguntas sobre cobertura y elegibilidad	888.690.2020	www.summit-inc.net
BlueCross Blue Shield de AZ Organización de Proveedores Preferidos	800.232.2345	www.azblue.com
International Medical Solutions	US: 928.446.6179 MEX: 690.1874	Inter-med-Solutions@hotmail.com www.internationalmedsolutions.com
Precertificación/Autorización previa	800.944.9401	www.summit-inc.net
Programa de medicamentos recetados	800.880.1188	www.summit-inc.net
SupportLinc EAP	888.881.5462	www.supportlinc.com
Symetra seguro de vida, muerte y desmembramiento accidental (AD&D)	520.287.6571	dzuniga@nogalesaz.gov
Comité del programa de bienestar de la Ciudad de Nogales Carmen Fuentes	520.287.6571	crojas@nogalesaz.gov
CBIZ Asesora de reclamos Angela Schlosser	520.321.7503	aschlosser@cbiz.com
CBIZ Gerente de cuentas Debbie Jamison	520.321.7513	djamison@cbiz.com
CBIZ Ejecutiva de cuentas Jennifer Aragon	520.321.7547	jaragon@cbiz.com

Recursos de vídeo



Explicación de términos de



¿Qué es el seguro de la vista?



Atención preventiva



Programas de asistencia al empleado



¿Qué es el seguro dental?



Seguro de vida y AD&D



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Acerca de este folleto: Este folleto destaca las características importantes de los beneficios de la Ciudad de Nogales para sus empleados elegibles para beneficios. Si bien se han hecho todos los esfuerzos posibles para garantizar la precisión de la información presentada, en caso de discrepancia, su cobertura y beneficios reales serán determinados por los documentos legales del plan y los contratos que rigen estos planes. Los planes de beneficios se pueden cambiar por cualquier motivo, en la medida en que lo permita la ley. Su participación en esta cobertura no es un contrato de trabajo y tampoco garantiza un empleo futuro.

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CBIZ Benefits & Insurance Services
1765 East Skyline Drive
June 2023 | Tucson, AZ 85718





2022-2023

EMPLOYEE BENEFITS GUIDE

**TOWN OF
ORO VALLEY**

BENEFITS AT A GLANCE

This is a high level listing of the Town of Oro Valley's (Town) comprehensive benefits package offering for eligible employees. This is not intended to provide a full description nor is it a guarantee of benefits. For additional information, please contact Human Resources at hr@orovalleyaz.gov or by calling (520) 229-4795.

Benefit	Is Coverage Automatic or Optional?	Paid by the Town	Paid by the Employee
Retirement – Defined Benefit			
- Arizona State Retirement System (ASRS) - Public Safety Personnel Retirement (PSPRS) - Corrections Officers Retirement System (CORP)	Automatic	X	X
Basic Life and Accidental Death & Dismemberment (AD&D)	Automatic	X	
Short Term and Long Term Disability	Automatic	X	
Employee Assistance Program	Automatic	X	
Medical and Prescription (2 plan options)	Optional	X	X
Dental (2 plan options)	Optional	X	X
Vision (2 plan options)	Optional		X
Health Savings Account with the High Deductible Health Plan Town annual contribution up to \$1750	Optional	X	X
Flexible Spending Account – Healthcare and Dependent Care	Optional		X
Retirement – Defined Contribution 457	Optional		X
Supplemental Life and Accidental Death & Dismemberment (AD&D)	Optional		X
Accident, Cancer, Critical Illness, Hospital	Optional		X
Legal Shield, ID Shield	Optional		X
Pet Insurance	Optional		X
Tuition Reimbursement – Up to \$3000 per year after 6 months of employment	Optional	X	X
Vacation Leave – Varies by years of service	Automatic	X	
Sick Leave – No maximum accrual limit	Automatic	X	
Holidays – 13 per year	Automatic	X	
Community Center / Aquatic Center Membership	Automatic	X	
On-site Health Clinic for those enrolled in Town's medical plan	Automatic	X	X

Employees hired to work a regular schedule of 20 or more hours per week, for 20 or more weeks per year, are eligible for the Town of Oro Valley benefits package.

Employees and their dependents are eligible for coverage under all benefits on the first of the month following 30 days from their date of employment.

Refer to all insurance carrier Summary Plan Descriptions, benefit summaries, and other plan documents for detailed benefit information, including limitations and exclusions.

MEDICAL, DENTAL, AND VISION

Per Pay Period Rates (24 per year)

	FULL-TIME EMPLOYEE RATES			PART-TIME RATES		
	Town Premium	Employee Premium	Know Your Numbers Premiums	Town Premium	Employee Premium	Know Your Numbers Premiums
UnitedHealthcare Choice Plus - PPO						
Employee Only	\$187.17	\$48.03	\$33.03	\$110.10	\$125.10	\$110.10
Employee + Spouse	\$459.66	\$138.86	\$123.86	\$291.76	\$306.76	\$291.76
Employee + Child(ren)	\$344.05	\$100.33	\$85.33	\$214.69	\$229.69	\$214.69
Employee + Family	\$682.60	\$213.18	\$198.18	\$440.39	\$455.39	\$440.39
UnitedHealthcare Choice Plus - HDHP						
Employee Only	\$189.67	\$15.00	\$0.00	\$94.84	\$109.84	\$94.84
Employee + Spouse	\$408.74	\$80.44	\$65.44	\$237.09	\$252.09	\$237.09
Employee + Child(ren)	\$328.41	\$56.44	\$41.44	\$184.93	\$199.93	\$184.93
Employee + Family	\$579.61	\$131.48	\$116.48	\$348.05	\$363.05	\$348.05
Delta Dental – Low Plan						
Employee Only	\$13.10	\$0.00		\$6.55	\$6.55	
Employee + Spouse	\$23.42	\$3.44		\$13.43	\$13.43	
Employee + Child(ren)	\$26.36	\$4.42		\$15.39	\$15.39	
Employee + Family	\$35.70	\$7.53		\$21.62	\$21.62	
Delta Dental – High Plan						
Employee Only	\$12.84	\$4.05		\$8.45	\$8.45	
Employee + Spouse	\$23.48	\$11.15		\$17.32	\$17.32	
Employee + Child(ren)	\$26.52	\$13.18		\$19.85	\$19.85	
Employee + Family	\$36.16	\$19.60		\$27.88	\$27.88	
EyeMed Vision – Low Plan						
Employee Only	\$0.00	\$2.93			\$2.93	
Employee + One	\$0.00	\$5.58			\$5.58	
Employee + Family	\$0.00	\$8.20			\$8.20	
EyeMed Vision – High Plan						
Employee Only	\$0.00	\$4.89			\$4.89	
Employee + One	\$0.00	\$9.29			\$9.29	
Employee + Family	\$0.00	\$13.65			\$13.65	

Know Your Numbers

Earn a \$15 per pay period discount by completing a biometric screening (labwork), review of your results with a healthcare provider, and certify you are tobacco-free or complete the tobacco cessation program available at the OV Employee Health Clinic. Program details available on Inside OV and through Human Resources.



ENROLLMENT

Click on this icon throughout the guide to watch videos detailing your benefits!



All benefit enrollments should be completed through Employee Self Service and must be completed during the designated annual Open Enrollment period, within 31 days of being hired into a benefits eligible position, or within 31 days of an IRS qualifying life event or status change.

Benefit Enrollment changes are only allowed mid-plan year due to an IRS qualifying life event. Examples of qualifying events include:

- Birth or adoption
- Loss or gain of insurance coverage
- Marriage, divorce, or legal separation
- Qualified medical court order
- Change in dependent care cost
- Change in dependent status affecting eligibility
- Unpaid leave of absence

If you experience a qualifying life event, you must report the event and provide appropriate documentation to Human Resources within the 31 day enrollment period.

Benefit Plan Eligibility

Employees hired to work a regular schedule of 20 or more hours per week, for 20 or more weeks per year, are eligible for the Town of Oro Valley benefits package.

You can enroll the following dependents in your benefit plans:

- Your legal spouse (not a domestic partner) and
- Your dependent children through the end of the month they attain age 26.

Social Security Numbers are required to enroll dependents in your benefits plans.



MEDICAL/PRESCRIPTION DRUG PLAN – UnitedHealthcare (UHC)

Medical and prescription drug plan coverage is offered through UnitedHealthcare. The Town continues to offer two plan options. Both plans include annual preventive and wellness exams covered at 100% when received from an in-network provider as well as access to the on-site Oro Valley Health Clinic. Services are available both in-network and out-of-network, but you will receive the highest level of coverage when visiting a participating UHC provider.

The PPO plan offers copays for a variety of routine services and prescriptions, paired with a low deductible and coinsurance responsibility for other major medical services. Once the out-of-pocket maximum is met for the plan, all medical and prescription services are covered 100%.

The High Deductible Plan (HDHP) includes 100% coverage for all medical services after the deductible is met. Before meeting the deductible, you pay the discounted, allowable UHC amount for in-network services and prescriptions. Once the out-of-pocket maximum is met, prescriptions are also then covered at 100%. The HDHP is paired with a Health Savings Account (HSA).

All deductibles and out-of-pocket maximums for both medical plans are administered on a calendar year basis.

Prescription Coverage

UHC's Pharmacy Benefit Manager, OptumRx, has developed a more affordable, high-performance network offering. The Value Pharmacy Network features a reduced number of retail pharmacies, while still providing access to tens of thousands of convenient pharmacy locations nationwide. Savings is achieved through lower negotiated fees and more aggressive discounts.

Pharmacies in the Value Network include **Walgreens, Fry's and Walmart** as well as **the mail-order pharmacy through Optum RX**.

Members on the High Deductible Health Plan are eligible for specified Preventive Prescriptions at no cost. View the Prescription Drug Lists for details.

Summary and Comparison of Plans

Refer to each plan's Summary of Benefit and Coverage and Summary Plan Description for further details, including out-of-network fees.

BENEFIT COVERAGE	PPO PLAN IN-NETWORK	HIGH DEDUCTIBLE HEALTH PLAN IN-NETWORK
Deductible (Individual ♦ Family)	\$750 ♦ \$1,500	\$2,800 ♦ \$5,600
Coinsurance	80% ♦ 20%	100% ♦ 0%
Max Out-of-Pocket (Individual ♦ Family)	\$2,500 ♦ \$5,000	\$3,500 ♦ \$7,000
Includes copays, deductible and coinsurance	Yes	Yes
Preventive Care		
Office Visits	Covered at 100%	Covered at 100%
Lab, X-Ray & Diagnostic	Covered at 100%	Covered at 100%
Primary Care Office Visits/Telehealth Visits	\$25	Covered at 100% after deductible is met
Specialist Office Visits/Telehealth Visits	\$25 – Premium Designated \$50 – Non Designated	Covered at 100% after deductible is met
Virtual Visit / Telemedicine	\$0 copay	Covered at 100% after deductible is met
Outpatient Lab	\$0 copay	Covered at 100% after deductible is met
Outpatient X-Ray & Diagnostics	\$25 copay	Covered at 100% after deductible is met
Specialty Scans (CT, PET, MRI, MRA)	Covered at 80% after deductible is met	Covered at 100% after deductible is met
Outpatient Surgery	Covered at 80% after deductible is met	Covered at 100% after deductible is met
Inpatient Hospitalization	Covered at 80% after deductible is met	Covered at 100% after deductible is met
Outpatient Mental Behavioral Health	\$0 copay	Covered at 100% after deductible is met
Outpatient Substance Abuse	\$0 copay	Covered at 100% after deductible is met
Rehabilitation Services	\$0 copay	Covered at 100% after deductible is met
Chiropractic Services	\$15 copay	Covered at 100% after deductible is met
Emergency Room	\$250 copay	Covered at 100% after deductible is met
Waived if admitted	Yes	Not Applicable
Urgent Care	\$40 copay	Covered at 100% after deductible is met
Convenience Care Clinics	\$25 copay	Covered at 100% after deductible is met
Prescriptions		
Retail	\$10 ♦ \$30 ♦ \$60	\$10 ♦ \$30 ♦ \$50 after deductible is met
Mail Order	\$20 ♦ \$60 ♦ \$120	\$20 ♦ \$60 ♦ \$100 after deductible is met

HEALTH SAVINGS ACCOUNT: OPTUM BANK

An HSA is a personal bank account that you own. You can use it to save money, income-tax free, to pay for qualified medical expenses. You can also save the money for a future need, even into retirement. HSA funds roll-over from year to year and the account is portable should you change health plans, retire or change employment.

Enrollment

Eligibility

To be eligible to enroll in and contribute to an HSA you must be enrolled in the Town's qualifying High Deductible Health Plan. Also, you **cannot**:

- Be covered by any other health plan (such as a spouse's plan) that is not a qualified HDHP.
- Be enrolled in Medicare, TRICARE or TRICARE for Life
- Cannot be claimed as a dependent on someone else's tax return
- Cannot have received VA or Indian Health benefits within the past three months (some exceptions apply)
- Cannot also be simultaneously covered by a health care flexible spending account (FSA) except in the case of a limited purpose FSA. Employees must have a zero balance in any active health care FSA on the start date of the HDHP.

If you are enrolling in the HDHP for the first time, the Town will initiate your enrollment with Optum Bank. Please be sure to respond to any additional verification requests from Optum Bank to complete your enrollment. You will automatically receive a welcome kit, account activation information and a debit card.

Contributions

You and the Town may contribute to an HSA up to the IRS designated annual maximum. Your contributions come out of 26 pay periods per year, and you can make changes to the amount anytime during the year. The Town will contribute twice each plan year. All contributions are tax-free and you own all contributions made to your account. Balances may also earn tax-free interest. Once your account balance reaches a determined amount, you can invest your HSA funds for increased earning potential.

2022 IRS Annual Maximum

Contribution Limits

(Employee + Employer Combined)

\$3,650 Employee Only

\$7,300 Family

+\$1,000 catch-up age 55+

Town of Oro Valley HSA Contributions

	JULY 2022	JANUARY 2023	PLAN YEAR TOTAL
Employee Only	\$500	\$500	\$1,000
Employee + One or More	\$875	\$875	\$1,750

Eligible Expenses

The IRS decides which expenses qualify to be paid from an HSA. You can find a list at [irs.gov](https://www.irs.gov). In general, you may use your HSA to pay for medical, dental and vision expenses. Expenses paid for outside of your medical plan will not count towards your HDHP deductible.

DENTAL: DELTA DENTAL

Two plan options are available: a Low Plan and a High Plan. On both plans, you will pay less when using a PPO provider. Delta Dental offers an additional network of Premier Dentists who may charge less than Out-of-Network Dentists. Billed charges are limited to the Premier amount allowed when using a Premier Dentist. When using an out-of-network dentist, you may be responsible for the dentist's total billed charges. Both Premier Dentists and Out-of-Network services are covered at a greater percentage on the High Plan.

BENEFIT COVERAGE	LOW PLAN PPO DENTIST	LOW PLAN PREMIER DENTIST OR OUT-OF-NETWORK	HIGH PLAN PPO DENTIST	HIGH PLAN PREMIER DENTIST OR OUT-OF-NETWORK
Annual Maximum per Person	\$1,750	\$1,000	\$2,000	\$1,000
Deductible (Ind./Family)	\$50/\$150	\$100/\$300	\$50/\$150	\$50/\$150
Waived for Preventive	Yes	Yes	Yes	Yes
Preventive	Covered at 100%	Covered at 60%	Covered at 100%	Covered at 80%
Basic	Covered at 80%	Covered at 40%	Covered at 100% Periodontics and Root Canal	Covered at 80% Periodontics and Root Canal
Major	Covered at 50%	Covered at 10%	Covered at 50%	Covered at 40%
Orthodontia (Child Only)	Covered at 50% up to a \$1,000 lifetime max - No deductible	Covered at 20% up to a \$500 lifetime max - No deductible	Covered at 50% up to a \$1,000 lifetime max - No deductible	Covered at 50% up to a \$1,000 lifetime max - No deductible

Note: Benefit amounts are based on a calendar year.

Selected Covered Services and Frequency Limitations

The chart is just an overview and not a complete description of the plan. Be sure to review the official Delta Dental Certificate of Insurance on Inside OV for more details, limitations and exclusions.

Preventive	
Oral Examinations	2 in 1 year
Cleanings	Low Plan: 2 in 1 year High Plan: 4 in 1 year (includes perio.)
Fluoride	Children to age 18 / 2 in 1 year
Bitewing X-rays	2 in 1 year
Full Mouth X-rays	1 in 3 years
Basic	
Periodontal Maintenance	4 in 1 year less the number of routine teeth cleanings
Space Maintainers	For children up to age 19: once per tooth area per lifetime
Emergency Palliative Treatment	Treatment for relief of pain
Sealants	For children up to age 19: 1 in 2 years for permanent molars & bicuspid
Amalgam & Composite Fillings	1 per surface in 2 years
Oral Surgery	Simple & Surgical Extractions
Major	
Crowns / Onlays / Implants	1 per tooth in 5 years
Dentures / Bridges (Prothodontics)	1 in 60 months
Periodontics	Treatment of gum disease; non-surgical 1 in 2 years. Surgical 1 in 3 years. High Plan - Basic Services
Root Canal	One per tooth High Plan - Basic Services

Orthodontia

- Dependent children are covered up to their 19th birthday. Children must be banded prior to age 17.
- All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia.
- Payable in 2 payments - 50% upon initial banding and 50% 12 months after.
- Orthodontic benefits end at cancellation of coverage.



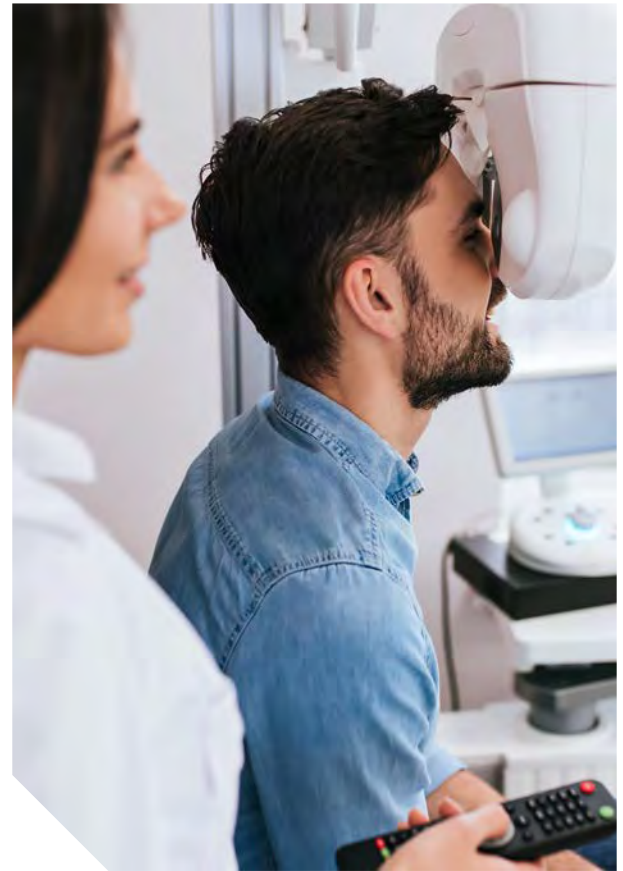
VISION PLAN – EYEMED

This voluntary plan allows you to visit a variety of providers, with the greatest level of benefit received when visiting a participating EyeMed INSIGHT network provider.

Summary of Benefits

VISION CARE SERVICES	LOW PLAN IN-NETWORK	HIGH PLAN IN-NETWORK
Network	INSIGHT	INSIGHT
Exam with dialation as necessary	\$10 copay	\$10 copay
Frames	20% off balance over \$120 allowance	20% off balance over \$160 allowance
Standard Lenses	\$25 copay	\$25 copay
Progressive Lenses Tiers 1 - 3	\$90 - \$135 copay	\$90 - \$135 copay
Contacts	\$135 allowance	\$160 allowance
Frequencies		
Exams	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 12 months
Lenses/Contacts	Once every 12 months	Once every 12 months

Refer to EyeMed's documents for further details including out of network reimbursement allowances



FLEXIBLE SPENDING ACCOUNTS – CBIZ FLEX

Flexible Spending Accounts (FSA) allow you to set aside part of your salary on a pre-tax basis to pay for medical, dental or vision and/or dependent day care expenses, reducing your taxable income and saving you money. Once you elect to participate, your election stays in place for the remainder of the plan year and can only be changed due to a qualifying life event. FSA contributions are spread out over 24 benefit deduction pay periods.

The Medical Spending Account enables you to set aside money to pay for uncovered health related expenses such as medical, dental and vision plan deductibles, copays and coinsurance, eyeglasses and contact lenses, prescription drug copays and more.

The Limited Purpose FSA pairs with a Health Savings Account, allowing you to set aside additional funds to cover dental and vision expenses.

The Dependent Care FSA gives you the opportunity to set aside pre-tax dollars to pay for dependent daycare expenses. Please be aware, that per the IRS, you cannot participate in this account and take a dependent daycare tax credit on your taxes at year end.

IRS "Use It Or Lose It" rule applies to these plans. Money not used by the end of the plan year will be forfeited.

2022-2023 Maximum FSA Contribution Amounts

	ANNUAL LIMIT	PER PAY PERIOD AMOUNT
Medical/Limited Purpose	\$2,850	\$118.75
Dependent Care	\$5,000	\$208.33

LIFE INSURANCE AND DISABILITY PLANS – Mutual of Omaha

The Town pays for basic life insurance, accidental death and dismemberment (AD&D) and short-term disability for all employees, plus long-term disability for Public Safety employees. Non-public safety employees have long-term disability coverage through the Arizona State Retirement System (ASRS). Please review the Certificates of Insurance on Inside OV for important plan details.

Life Insurance & Short Term Disability

- **Life and AD&D** - Each eligible employee is covered for 1 times your annual salary up to a maximum of \$200,000.
- **Short Term Disability** - Begins after an elimination period of 90 days of disability. Benefits provide you with 66.67% of your weekly earnings as income replacement up to a weekly maximum benefit of \$2,000, for up to 13 weeks.

Long Term Disability - Public Safety Employees (PSPRS and CORP employees)

- After a 180 day elimination period, benefits provide you with 66.67% of your monthly earnings as income replacement up to a monthly maximum benefit of \$6,700.

Long Term Disability - Non-Public Safety Employees

- The Town contributes to the Arizona State Retirement System (ASRS) for long-term disability income protection. Employees wishing to inquire about this benefit can go on-line to www.azasrs.gov or call the ASRS at 520-239-3100 (Tucson office).

Voluntary Life / AD&D

You have the option to purchase additional life and AD&D insurance for you and your spouse, as well as additional term life insurance for your child(ren). The premiums for this employee-paid benefit are paid through payroll deduction. To purchase insurance for your spouse and/or child(ren) you must first have additional insurance for yourself in an equal amount.

Guaranteed Issue

When applying for this benefit when you are first eligible as a new hire or as a result of a promotion to a benefits-eligible position, you are eligible for up to a specified amount of guaranteed issue coverage (GIA), not subject to Evidence of Insurability (EOI). The GIA for Employee Voluntary Life is \$100,000; \$30,000 for Spouse Voluntary Life. When selecting an amount above the GIA, you will need to complete an EOI online through Mutual of Omaha at www.mutualofomaha.com/eoi.

Coverage Guidelines

	MINIMUM	GIA	MAXIMUM
Employee Life	\$10,000	5 times annual salary, up to \$100,000	5 times annual salary, up to \$500,000
Spouse Life	\$5,000	100% of employee's benefit, up to \$30,000	100% of employee's benefit, up to \$250,000
Child Life	\$5,000	100% of employee's benefit	100% of employee's benefit, up to \$10,000

Annual Open Enrollment Amount Increase: If you are already enrolled in Employee Voluntary Life, you may increase your amount by \$10,000, up to GIA, without completing an EOI.

For Late Entrants: all coverage amounts will require an EOI.

Living Care/Accelerated Death Benefit: 80% of the amount of the Town-paid life insurance benefit is available to you if terminally ill, not to exceed \$160,000.

Waiver of Premium: If it is determined that you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions.

Age Reductions and Exclusions

- At age 65, amounts reduce to 65%
- At age 70, amounts reduce to 50%

Voluntary Life Insurance Premiums

Please note that the premium amounts may vary slightly from the enrollment selection, due to rounding. Premiums are deducted on a **post-tax** basis.

To select your benefit amount and calculate your premium:

- Locate the benefit amount you want from the top row of the table.
- Find your age bracket in the far left column. (Current age for new hires, the age you will be as of July 1st for Open Enrollment).
- Your premium amount is found in the box where your age and benefit amount intersect.

If the benefit amount you wish to select is greater than any amount in the table, select the benefit amount from the top row that when multiplied by another number results in the benefit amount you want. For example, if you want \$150,000 in coverage, you obtain your premium amount by multiplying the rate for \$50,000 times three.

Employee Voluntary Life (24 payroll deductions per year)

AGE	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000
0-29	\$0.50	\$1.00	\$1.50	\$2.00	\$2.50	\$3.00	\$3.50	\$4.00	\$4.50	\$5.00
30-34	\$0.55	\$1.10	\$1.65	\$2.20	\$2.75	\$3.30	\$3.85	\$4.40	\$4.95	\$5.50
35-39	\$0.60	\$1.20	\$1.80	\$2.40	\$3.00	\$3.60	\$4.20	\$4.80	\$5.40	\$6.00
40-44	\$0.85	\$1.70	\$2.55	\$3.40	\$4.25	\$5.10	\$5.95	\$6.80	\$7.65	\$8.50
45-49	\$1.35	\$2.70	\$4.05	\$5.40	\$6.75	\$8.10	\$9.45	\$10.80	\$12.15	\$13.50
50-54	\$2.15	\$4.30	\$6.45	\$8.60	\$10.75	\$12.90	\$15.05	\$17.20	\$19.35	\$21.50
55-59	\$3.30	\$6.60	\$9.90	\$13.20	\$16.50	\$19.80	\$23.10	\$26.40	\$29.70	\$33.00
60-64	\$5.05	\$10.10	\$15.15	\$20.20	\$25.25	\$30.30	\$35.35	\$40.40	\$45.45	\$50.50
65-69	\$8.95	\$17.90	\$26.85	\$35.80	\$44.75	\$53.70	\$62.65	\$71.60	\$80.55	\$89.50
70-74	\$15.85	\$31.70	\$47.55	\$63.40	\$79.25	\$95.10	\$110.95	\$126.80	\$142.65	\$158.50
75-79	\$26.05	\$52.10	\$78.15	\$104.20	\$130.25	\$156.30	\$182.35	\$208.40	\$234.45	\$260.50

Spouse Voluntary Life (24 payroll deductions per year)

Rates are based on your age.

AGE	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
0-29	\$0.25	\$0.50	\$0.75	\$1.00	\$1.25	\$1.50	\$1.75	\$2.00	\$2.25	\$2.50
30-34	\$0.28	\$0.55	\$0.83	\$1.10	\$1.38	\$1.65	\$1.93	\$2.20	\$2.48	\$2.75
35-39	\$0.30	\$0.60	\$0.90	\$1.20	\$1.50	\$1.80	\$2.10	\$2.40	\$2.70	\$3.00
40-44	\$0.43	\$0.85	\$1.28	\$1.70	\$2.13	\$2.55	\$2.98	\$3.40	\$3.83	\$4.25
45-49	\$0.68	\$1.35	\$2.03	\$2.70	\$3.38	\$4.05	\$4.73	\$5.40	\$6.08	\$6.75
50-54	\$1.08	\$2.15	\$3.23	\$4.30	\$5.38	\$6.45	\$7.53	\$8.60	\$9.68	\$10.75
55-59	\$1.65	\$3.30	\$4.95	\$6.60	\$8.25	\$9.90	\$11.55	\$13.20	\$14.85	\$16.50
60-64	\$2.53	\$5.05	\$7.58	\$10.10	\$12.63	\$15.15	\$17.68	\$20.20	\$22.73	\$25.25
65-69	\$4.48	\$8.95	\$13.43	\$17.90	\$22.38	\$26.85	\$31.33	\$35.80	\$40.28	\$44.75

Child Voluntary Life (24 payroll deductions per year)

\$5,000	\$10,000
\$0.30	\$0.60

VOLUNTARY BENEFITS AVAILABLE THROUGH COLONIAL LIFE

These voluntary insurance products are compatible with insurance coverage offered by the Town, are guaranteed-renewable and fully portable. Policies and rates are individually-based. To learn more or enroll in these benefits, please contact Colonial Life directly. You will need the per pay period rates to complete your online enrollment for your benefits.

These pre-tax plans are available:

- **Accident Insurance** helps offset the unexpected medical expenses that can result from a covered accidental injury.
- **Cancer Insurance** helps offset out-of-pocket expenses related to cancer.

To Enroll Contact a Colonial Life agent:

Heidi Plett (520) 237-1136

Paul Bynum (520) 747-0583

To learn more or to sign up for a 1-to-1 session visit:
www.visityouville.com/en/TownofOroValley

These post-tax plans are available:

- **Disability Insurance** replaces a portion of your income if you become disabled from a covered accident or sickness.
- **Life Insurance** enables you to tailor coverage for your individual needs.
- **Critical Illness Insurance** supplements your major medical coverage by providing a lump-sum benefit.
- **Hospital Confinement Indemnity Insurance** provides a lump-sum benefit for a covered hospital confinement or a covered outpatient surgery.

LEGALSHIELD AND ID SHIELD

LegalShield: Protect you and your family with a legal services plan which gives you the opportunity to talk to an attorney about any personal matter without worrying about high hourly costs. This plan includes unlimited legal consultation, standard will preparation, letters and phone calls on the member's behalf, legal document review and 24/7 emergency assistance.

IDShield: This service monitors your credit, identity and security with alerts, consultation with licensed private investigators and full identity restoration. It includes an unlimited service guarantee, and \$1 million reimbursement coverage.

Both plans include **LegalShield MemberPerks** which gives you dozens of member discounts at popular retailers. Members save an average of \$50-\$150 per month with discounts from retailers, restaurants and nationally known brands.

Per Pay Period Cost

	LegalShield	IDShield	COMBINED
Individual	\$9.48	\$4.48	*\$13.95
Family	\$9.48	\$9.48	*\$16.95

* Discount if Family LegalShield and Family IDShield purchased together.

PET INSURANCE



Learn more at

www.petinsurance.com/townoforovalley

<https://www.petinsurance.com/resourcecenter/>

or call 877-738-7874



90% cash back

Use any vet and get 90% reimbursement on the bill



Open to all ages

No age limits or age-based premium increases



More than just accident & illness coverage

Spay/neuter, hereditary, Rx, therapeutic diets, dental, and more

RETIREMENT SAVINGS PLANS



EMPOWER

The Town offers eligible employees the opportunity to participate in the Town of Oro Valley 457(b) Plan, a tax deferred retirement savings plan which supplements your ASRS, PSPRS, and CORP retirement benefit.

Features of the 457(b) Plan include:

- Pre-Tax and Roth after-tax contributions.
- Investment & Retirement planning tools, including personalized estimate of income replacement.
- Online investment advice and account management provided by Empower Retirement Advisory Services. There is no guarantee provided by any party that participation in any of the advisory services will result in a profit.

Start by registering your account at empowermyretirement.com

- Log on and select *Register*.
- Choose the *I do not have a PIN* tab.
- Follow the prompts to create your username and password.

If we don't have your email or phone number on file from your employer, or if you have another account with Empower (with a former employer, for example), you will need to call to access your new plan account.

For more help, call 800-701-8255

Representatives are available weekdays Monday through Friday 6am-8pm and Saturdays 7am-3:30pm Mountain time.

Employees who are hired to work a regular schedule of 20 or more hours per week, for 20 or more weeks per year, are automatically enrolled in one of the following retirement plans.

Arizona State Retirement System (ASRS)

- for non-sworn law enforcement personnel
www.azasrs.com

- New employees are required to register online to establish their account for receipt of payroll contributions.
- Registration for secure access to your account also enables employees to take advantage of the many excellent retirement planning resources on the website.

Fiscal Year 2023 Contribution Rates
Effective July 1, 2022

Contributor	Pension & Health Insurance Benefit	Long Term Disability Income Plan	Total
Employee	12.03%	0.14%	12.17%
Employer	12.03%	0.14%	12.17%

Public Safety Personnel Retirement System (PSPRS)

- for sworn law enforcement personnel
www.psprs.com

- New employees will be emailed a registration link from PSPRS to establish your account and to select from two retirement plan options no later than 90 days after hire.
- Which plan is right for you? See the New Members Page at www.psprs.com for videos and additional resources regarding the plans, contribution rates and retirement eligibility.
- Employee and the Town both contribute to the retirement plans. Rates are based on date of hire and plan selection.

Serving Those Who Serve Others

ORO VALLEY HEALTH CLINIC (520) 229-5334



Monday, Wednesday, and Friday: 9 am to 3 pm | Thursday: 9am to 5pm
Lab Hours: Thursday: 7 am to 9 am

The Town of Oro Valley provides on-site medical care through Healthcare Solutions (HCS) with a dedicated team of Family Nurse Practitioners that is committed to providing personalized patient care. The OV Employee Health Clinic is open to all employees and dependents enrolled in the Town's medical insurance plans. With the exception of non-preventive laboratory services, all medical and wellness services at the Clinic are provided to you and your eligible dependents at no cost. See list of services →

All medical care sought at the OV Employee Health Clinic is private and confidential, with medical records secured by HCS. The Clinic is staffed on Monday, Wednesday and Friday by a certified Family Nurse Practitioner (FNP). On Thursdays a nurse is available and lab work may be obtained from 7am-9am. The FNP has a full scope of practice and can assess, diagnose, prescribe medications and order additional tests such as radiology and labs as needed. The nurse works under the direction of the FNP and will follow up on your health while running programs such as weight loss, stress & anxiety, smoking cessation and disease management. The clinicians build trusting confidential relationships and become your healthcare advocates.

HCS recommends that all benefited employees and covered dependents become established patients. By being an established patient, HCS will be able to triage patient symptoms over the phone and can refill most medications without an office visit as well as give medical advice. With electronic medical records, clinicians do not have to be onsite to treat patients. This allows HCS practitioners to be available for patients five days a week.

Services Offered

- Physical exams
- Wellness checks
- Annual flu shots
- Treatment of acute infections (ear, tonsils, cold, flu)
- Diagnosis and treatment of chronic health conditions (asthma, diabetes, arthritis, hypertension, depression)
- Order and interpret lab tests and x-rays
- Prescribe and manage medications
- Personal healthcare coordination
- Suture wounds
- Counseling and treatment for sexually transmitted diseases
- Weight loss plans
- Referrals to specialists
- Free smoking cessation
- COVID Testing

Pediatric Services Offered

- Sore throat
- Common cold
- Earache
- Flu
- Pink eye
- Seasonal allergies
- Breathing treatments – asthma
- Rashes
- Eczema
- Sprains & strains (refer for X-rays)
- Sports physicals
- School physicals

Your Claims Advocate

If you have been unable to resolve medical, dental, or vision billing questions, Angela Schlosser from CBIZ is available to assist you.

(520) 321-7503
aschlosser@cbiz.com



Virtual Visits

Get 24/7 access to care with Virtual Visits. You can use choose Teledoc, Amwell or Doctors on Demand, and use your mobile device or computer without an appointment. Log on to myuhc.com or the UHC Health4Me app to begin.

Common conditions treated include: allergies, cold / flu, ear infections, rash and sinus infections

Why is UHC calling?

Care coordinators may contact you to offer free and confidential health services to help you manage a health condition.

EMPLOYEE ASSISTANCE PROGRAM

All employees are provided a 100% paid Employee Assistance Program (EAP) through Alliance Work Partners (AWP). Services are available to any household member, regardless of age or relationship, residing in your home, including significant others and their children.



YOUR EAP BENEFITS INCLUDE	
6 Counseling Services	Per issue, per year, per family member. Short-term counseling sessions which include assessment, referral, and crisis services.
Safe Ride Program	Encourages employees and their immediate family members whose driving may be impaired to call a cab. With a saved receipt, participants will be reimbursed by AWP.
Worklife	Resources and referrals for everyday needs. Available by telephone.
HelpNet	Customized website provides participants with a summary of your service package, training, orientation, resource articles, tips and tools on balancing work and family life.
Postural Therapy (PTX)	An online postural therapy exercise "engine", accessible from any computer, tablet, or phone. Virtual therapy to improve posture and in turn, reduce muscle and joint pain.

Effective July 1, 2022 AWP can be reached through their confidential phone number at 800-343-3822. Counselors are available to talk with you 24 hours a day, 7 days a week, 365 days a year.

You can also go to www.awpnow.com to learn more about your EAP services.

EMPLOYEE WELLNESS PROGRAM



The wellness program is a collaboration between the Town, the Wellness Council of Arizona (WELCOAZ), United Healthcare, and the OV Employee Health Clinic.

This program is designed to help you develop and maintain healthy living strategies along with building an enhanced work environment. The program is supported by an active wellness committee with representatives throughout the Town.

Employee wellness initiatives focus on all aspects of well-being, including physical activity, healthy eating, stress management, preventive health, financial wellness, social wellbeing and more. Along with an emphasis on a healthy environment and group activities, offerings give you resources to customize your own wellness program and work towards what's important for you. Throughout the year you will see workshops, wellness challenges, health bulletins, on-site activities and special events such as Mobile Onsite Mammography Clinic.





On-site Wellness Council of Arizona (WELCOAZ) Health Coaching

All employees are invited to participate in personalized, confidential one-on-one health coaching with a certified personal trainer and wellness coach. Whether you are looking to improve your eating habits, start a new exercise routine, manage a chronic condition, learn and practice stress management strategies or just enhance your personal health, WELCOAZ is here to help. Sessions are available on-site most Tuesdays, with special activities offered throughout the year.

Oro Valley Community Center and Aquatic Center

Bring your badge for complimentary access to these excellent Oro Valley facilities. Family members may purchase memberships or drop-in passes.

Healthy Rewards

Work towards a personal health goal and earn a \$75 reward when achieving a goal or to reimburse yourself for a purchase to support you in achieving a goal. Work with a nurse at the OV Employee Health Clinic or a health coach with the Wellness Council of Arizona. These free and valuable resources will provide encouragement, direction, and information needed to support your success.

Smoking Cessation Program

A smoking cessation program will now be made available at the Oro Valley Employee Health Clinic – free of charge. Oro Valley Employee Health Clinic hours are Monday, Wednesday, and Friday: 9 am to 3 pm, and Thursday: 9am to 5pm.

WellCoAz Healthy Tracks

A six month intuitive eating program delivered through multiple platforms; individual health assessments, live and recorded monthly lectures, at least monthly individual or group coaching sessions (all lectures and sessions approximately 30 – 60 minutes in length). Intuitive Eating focuses on Stages of Change, Healing Foods, Micro and Macro Nutrients, and Building Self-Confidence for Better Health. Sign up through the health coach.

Wellness Program Disclosure Notice of Alternative Standards

Your health plan is committed to helping you achieve your best health status. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. By contacting the Town Wellness Coach she will work with you to find a wellness program with the same reward that is right for you in light of your health status.

CONTACT INFORMATION

Town of Oro Valley Human Resources

520-229-4795
hr@orovalleyaz.gov

Medical/Prescription Drug Plan – UnitedHealthcare (UHC)

www.myuhc.com | 866-633-2446
Plan Number 717067

OV Health Clinic

520-229-5334 or 602-424-2101
<https://healthcaresolutionscenterstownoforovalley.as.me/schedule.php>

Health Savings Account (HSA) – Optum Bank

www.optumbank.com | 800-791-9361
Plan Number 717067

Flexible Spending Accounts – CBIZ Flex

www.myplans.cbiz.com | 800-815-3023
“My Plans by CBIZ” Mobile App Available

Dental – Delta Dental

Find a Dentist: deltadentalaz.com/provider-search
Member Connection: deltadentalaz.com/member
Customer Service, Claims or Benefit Inquiries:
800-352-6132, opt. 1
Group Number 31983

Vision Plan – EyeMed

www.eyemedvisioncare.com | 866-299-1358
Plan Number 9792318

Employee Assistance Program (EAP) – Alliance Work Partners

www.awpnow.com
800-343-3822

Life Insurance & Disability: Mutual of Omaha

www.mutualofomaha.com/customer-service
800-877-5176 | Plan Number G000B6MB
Evidence of Insurability (EOI):
www.mutualofomaha.com/eoi

Voluntary Benefits - Colonial Life

Heidi Plett | Heidi.Plett@coloniallifesales.com
Paul Bynum | Paul.Bynum@coloniallifesales.com |
520-747-0583
www.coloniallife.com | 520-237-1136

LegalShield and IDShield Plans

Cassie Prinke | legalhelp@cox.net
www.legalshield.com | 602-999-9643

Retirement Savings Plans - Empower

457 and Roth Plans
Cory Sprott Cox | Cory.SprottCox@empower.cox |
520-479-4852
Participant Services | 800-701-8255
empowermyretirement.com

WELCOAZ On-site Health Coaching

Joan Upton, Wellness Coach
healthcoach@orovalleyaz.gov | 520-229-4727

Arizona State Retirement System (ASRS)

www.azasrs.gov | 520-239-3100

Public Safety Retirement System (PSPRS)

www.psprs.com | 877-925-5575

Pet Insurance - Nationwide

www.petinsurance.com/townoforovalley
877-738-7874

Mandated health plan information and required Federal notices available on the inside OV SharePoint site - Human Resources Department page

CBIZ Benefits & Insurance Services, Inc.
1765 East Skyline Drive • Tucson, AZ 85718
FINAL 4.2022 (520) 327-6421





**EASTERN
ARIZONA
COLLEGE**

2023
EASTERN ARIZONA COLLEGE
BENEFITS
GUIDE



PRESIDENT'S WELCOME



TODD HAYNIE

Eastern Arizona College is a great place to work. The work we do here changes the lives of those who attend. And your role at EAC is vital to this effort.

As the oldest community college in the state, and nestled in the Gila Valley, Eastern Arizona College is steeped in a tradition of excellence. EAC has developed a long history of academic excellence and student success. The degrees and certificates we offer to students who choose to attend prepare them to transfer to the university of their choice or enter the job market with excellent skills.

When I attended EAC in the late 80s and early 90s, the College had a motto: “Excellence, Achievement, and Commitment.” That later changed to “Futures Begin at EAC.” Now we proclaim *at EAC we change lives*. Although the words have evolved, the message is the same: We want students to be successful. We work to provide them a great campus environment that is welcoming and conducive to a great academic experience. We also invite our community

to campus to enjoy the rich fine arts, athletic, and other community and academic experiences that make the College the crown jewel of the Gila Valley.

As we strive toward engaging our community and providing an environment for our students to be successful, all with a keen eye on being fiscally responsible, we can continue to extend the reach of this institution to many future generations of EAC students.

In 2021, Eastern Arizona College was named the “Best Place to Work” by the readers of the *Eastern Arizona Courier* and *Copper Era* newspapers. I’m grateful for this recognition because I believe it is true. EAC is the best place to work, *because of you*.

Thank you for all you do to make Eastern Arizona College a strong institution. Go Monsters!

Todd Haynie

President

todd.haynie@eac.edu

A handwritten signature in black ink that reads "Todd Haynie". The signature is fluid and cursive, with the first name "Todd" being more prominent.

BENEFITS OVERVIEW

Welcome to Eastern Arizona College!

We strive to provide a competitive and comprehensive benefits package offering health and welfare benefits, retirement, paid leave and more. The college pays the greatest portion of your benefits, passing along a fraction of the total cost to employees.

Eligibility

Employees classified as regular full-time faculty or staff are able to elect coverage for themselves and all of their eligible dependents under the medical, dental, vision and dependent life benefit programs. EAC offers two tiers of coverage for health, dental and vision insurance:

- Employee Only
- Employee Plus Family

You may choose different coverage categories for different plans. For example, you may elect Employee plus Family medical and Employee Only dental.

Social Security numbers and dates of birth must be provided for all plan participants, including dependents. You may be required to provide documentation supporting dependent eligibility before coverage begins on any of the benefit plans.

Who is an eligible dependent?

- Your legal spouse
- Your natural child, legally adopted or placed for adoption or stepchild under age 26
- Foster children under 26
- A child for whom legal guardianship has been awarded to you or your legal spouse, under age 26

- A child for whom insurance is required through a Qualified Medical Child Support Order, court order, or administrative order
- A child of any age who is, or becomes, disabled and is dependent upon you

Note: All dependents age 26 and older must be approved as a disabled dependent and you will be required to submit documentation as proof of guardianship.

Change in Status

Generally, the coverage you elect remains in effect for the entire plan year, which runs January 1 through December 31. If you experience a qualifying event during the year, you may be eligible to change your coverage. Election changes must be made within 31 days of the qualifying event. Any change you make must be consistent with the change in your family circumstances. An example of a change consistent with family circumstance would include adding your new baby to your medical coverage at the child's birth; however, the child's birth would not allow you to add your spouse to your dental coverage. Unless you experience a qualifying event, changes cannot be made to your benefits until the next open enrollment period.

Qualifying events include:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or qualified dependent
- Change in employment status or in coverage under another employer-sponsored plan

FLEXIBLE SPENDING PROGRAM

The Flexbenefit Plan shall cover the cost of the employee only level of coverage for the PPO 350 health insurance plan. For those that enroll in the HDHP, the difference in premium from the employee only level of coverage of the PPO 350 Plan and the employee only level of coverage for the HDHP is paid into an employee's Health Savings Account (HSA) as the employer contribution.

An additional cash flex amount of \$9,325 is provided to help pay other qualified insurance choices and/or take as taxable wages if not used for premiums as illustrated in the tables below.

The flex benefit and cash flex is provided by EAC as a non-mandated benefit and is subject to change with or without notice.

EAC Paid Flex Benefit	Monthly	Annually
Employee Base	\$760	\$9,120
Cash Flex	\$777	\$9,325
Total Flex Benefit	\$1,537	\$18,445

Medical Monthly Premiums	Employees Only	Employee + Family
BCBS PPO Base	\$760	Additional \$790 = \$1,550 Total
BCBS HDHP	\$570	Additional \$705 = \$1,275 Total

Dental Monthly Premiums	Employees Only	Employee + Family
Delta Dental	\$47.54	Additional \$99.20 = \$146.74 Total

Vision Monthly Premiums	Employees Only	Employee + Family
VSP Vision	\$7.67	Additional \$8.82 = \$16.49 Total

HEALTH SAVINGS ACCOUNT (HSA)

HEALTH SAVINGS ACCOUNT (HSA)

If you have a high deductible health insurance plan (HDHP), an HSA can help provide some security for your health care costs and limit out-of-pocket expenses.

Your HSA funds can help you manage health care expenses such as copays, deductibles, prescriptions, over the counter medicines, coinsurance, dental, and vision care expenses.

[Click here for a full list of IRS eligible expenses.](#)

An HSA is a tax-advantaged savings account that can be used for your health care expenses. Your contribution comes out of each paycheck on a pre-tax basis, and is deposited into an HSA account that you own.

IMPORTANT: It is your responsibility to know if you are eligible for an HSA. It is also your responsibility to maintain records of your expenses.

2023 IRS Maximum Annual Contribution

HDHP Tier	Total Limit	Contributed by EAC	Remaining for Employee Contribution	Max per Month Deduction
Employee Only Coverage	\$3,850	\$2,280	\$1,570	\$130.83
Employee + Family Coverage	\$7,750	\$2,280	\$5,470	\$455.83

Six (6) months of the employer HSA contributions are automatically placed in the employees HSA account upon initial enrollment. Regular monthly employer contributions will be deposited monthly starting on the seventh month of coverage.

WHAT ARE THE RULES TO HAVE AN HSA?

- All Rules are determined by the IRS
- You must enroll on one of the HDHP medical plans
- You may not be enrolled in any other traditional medical plan with copays
- You cannot be enrolled in Medicare, ACCCHS or Tricare
- You cannot have a Medical FSA

ADVANTAGES OF AN HSA

- An HSA can help you save money and pay for health care costs like deductibles and coinsurance.
- EAC contributes \$2,280 each year
- You can make contributions too.
- If you're age 55 or older you can contribute an additional \$1,000 catch up amount
- There's no "use it" or "lose it" clause. Unspent money rolls over every year
- The money is yours to keep when you retire or if you leave
- At age 65, you can use the money for non-medical expenses without a penalty, like a 403b

TRIPLE TAX BENEFITS:

- The money you deposit into your HSA is tax-free
- Your money gains interest tax-free
- You can withdraw it tax-free for any qualified medical expenses

[Click to Download the Mobile App](#)



BlueCare AnywhereSM telehealth app provides flexible, affordable, and convenient healthcare when your primary doctors aren't available. You can visit with a provider, counselor, or psychiatrist any day, any time – from your smartphone, computer, or tablet.

Three Types of Telehealth Care Available

- 

MEDICAL
When an employee doesn't have a regular doctor or their primary care provider isn't available, BlueCare Anywhere providers are here to help with a range of common illnesses, aches, and pains. They can also prescribe medication, if necessary.
- 

COUNSELING
Licensed psychologists or counselors are available to treat issues – such as mental health and substance abuse – that can affect emotional, psychological, and social well-being. By appointment only.
- 

PSYCHIATRY
Board-certified psychiatrists are available for assessments, evaluation, treatment, and can prescribe medication. By appointment only.

BlueCare Anywhere Telehealth Type of Visit	HDHP \$3,500 Plan	PPO \$350 Plan
Medical Visit	\$64	\$0
Counseling Visit	\$90 – \$115	\$20
Psychiatric Visit	\$95 – \$250	\$45



DOWNLOAD THE **BlueCare Anywhere** APP
OR VISIT **BlueCareAnywhereAZ.com** NOW.

MEDICAL PLANS



Description of Coverage	HDHP \$3,500 Plan	PPO \$350 Plan
	In Network	In Network
Deductible (Individual / Family)	\$3,500 / \$7,000	\$350 / \$1,050
Coinsurance	0% after deductible	20% / 80%
Out of Pocket Maximum <i>(Includes deductibles, coinsurance, medical copays and pharmacy copays)</i>	\$6,650 / \$13,300	\$4,500 / \$9,000
Medical Services		
Primary Care Physician (PCP)	0% after deductible	\$25 copay
Specialist	0% after deductible	\$35 copay
Preventive care <i>(Wellness / Well Child Care / Immunizations)</i>	100% covered	100% covered
Hospitalization	0% after deductible	\$200 then 20% after deductible
Outpatient Services <i>(Facility / Surgery)</i>	0% after deductible	20% after deductible
Outpatient Lab & X-ray <i>(in physician's office or independent free - standing facility)</i>	0% after deductible	\$25 copay
Complex Diagnostic Testing	0% after deductible	20% after deductible
BlueCare Anywhere Virtual Visits	\$64	\$0
Urgent Care	0% after deductible	\$50 Copay
Emergency Room	0% after deductible	\$100 per member/facility/day, then 20% after deductible

PRESCRIPTION COVERAGE

	HDHP \$3,500 Plan	PPO \$350 Plan
Retail <i>(Tier 1 / Tier 2 / Tier 3)</i>	0% after deductible	\$15 / 20% after deductible / 30% after deductible
Specialty Rx <i>(Tier A / Tier B / Tier C / Tier D)</i>	0% after deductible	\$30 / \$60 / \$90 / \$120
Mail Order	0% after deductible	2 retail copays

LOCATE A BCBSAZ PROVIDER NOW



DELTA DENTAL

Delta Dental offers the flexibility to choose any dentist when you need dental care, but you will save the most when you use a dentist in the Delta Dental PPO network. The following chart outlines the dental benefits we offer. Members may incur higher out-of-pocket costs when seeing a premier network or out-of-network dentist.

	PPO PLUS PREMIER
	PPO Network, Premier Network and Out-of-Network
Benefits	
Plan Year Maximum	\$2,500
Plan Year Deductible (Individual/Family)	\$50 / \$150
Services (per plan frequency and limitations)	<i>Delta Dental Pays</i>
Exams, Routing Cleanings and X-rays	100%
Fillings, Endodontics, Periodontics, Extractions and Surgical Procedures	80%
Crowns, Bridges, Partial Dentures and Implants	50%
Orthodontics	
Benefits for adults and children 8 years of age or older.	50% to a lifetime maximum of \$1,500

VSP VISION

With VSP, you may visit any vision provider, but you will pay lower copays and save the most when you visit providers within the VSP network.

Coverage includes lenses and frames, anti-reflective lens coating for glasses and contact lenses in lieu of glasses. For laser vision correction, the average discount is 15%.

	IN NETWORK
Examination (Once Every 12 Months)	\$10 Copay
Contact Lens Exam + Fit and Follow Up (Once Every 12 Months)	Up to \$60
Lenses (Once Every 12 Months) Single / Bifocal / Trifocal Standard Progressive	\$25 Copay
Frames (Once Every 24 Months)	\$150 featured brand allowance / \$130 standard Walmart, Sams Club allowance, \$70 Costco allowance. 20% discount over allowance.
Contact Lenses – instead of glasses (Once Every 12 Months) Elective Medically Necessary	Up to \$60 Copay; \$130 allowance Covered in full
Laser Vision Correction	15% off retail price or 5% off discounted price

LIFE INSURANCE



BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT

EAC understands that the emotional stress related to losing a loved one is difficult enough. And while it's hard to think about, would your family have the financial protection they'll need if you pass away? Term Life insurance can help offer you the peace of mind that your family will not suffer an undue financial burden during a time that's already difficult enough.

EAC pays for these benefits on your behalf as a benefit eligible employee.

Why is Life and AD&D Insurance Important?

Term Life insurance can provide your loved ones with financial security if you're no longer there to support them. This paired with AD&D insurance can help pay for the unexpected costs that may arise from a covered accident.

**ACT FAST— ENROLLMENT
OPPORTUNITY DURING 2023
OPEN ENROLLMENT**

Benefit Summary		
	Faculty & Staff	Administration
Life Benefit <i>Reduces by 50% at 70 years</i>	3 x annual salary up to \$50,000	3 x annual salary up to \$500k max and guaranteed issue amount of \$325k

VOLUNTARY LIFE & AD&D

Employee

- **GUARANTEED ISSUE OF \$200,000**
- Maximum of 7 X salary to \$500,000
- 10K increments

Spouse

- **GUARANTEED ISSUE OF \$20,000**
- Maximum of \$250,000
- 10K increments
- Not to exceed 50% of employee benefit

Child

- **GUARANTEED ISSUE UP TO \$10,000**
- Increments of \$2,000, \$4,000, \$6,000, \$8,000 or \$10,000
- Not to exceed 50% of employee benefit

TAKE ACTION - During 2023 Open Enrollment - THANK YOU!

Enroll up to Guaranteed Issue amount during this open enrollment only!

Newly Hired Employees

A special guaranteed issue opportunity is available for newly hired employees during their initial 30 day enrollment period. No Evidence of Insurability is required for **guaranteed amounts listed above**.

Annual Enrollment - Enrolled Employees

Evidence of Insurability is not required for the during Open Enrollment to increase up to an additional **\$50,000** (provided the resulting amount does not exceed \$200,000 of total coverage)

Evidence of Insurability (EOI) is required for elections above the guaranteed amounts and all other elections.

VOLUNTARY SHORT-TERM DISABILITY

Disability insurance can pay you benefits if you suffer a covered disability. Think of it as insurance for a portion of your paycheck. Payments may come directly to you or someone you designate. Benefit is 100% employee paid. No medical questions asked if enrolling when first eligible.



Weekly Benefit	Maximum Weekly Benefit	Required minimum days of continuous disability	Maximum benefit period (includes benefit waiting period)
66 2/3% of your weekly covered earnings	\$2,000	45 days for Accident 45 days for Sickness	19 weeks

RETIREMENT



ARIZONA STATE RETIREMENT SYSTEM (ASRS)

Employees participate in the Arizona State Retirement System (ASRS) in accordance with the statutes of the State of Arizona. As a defined benefit retirement plan, the ASRS pays retirement benefits determined by a set formula. A member's benefit is equal to the average monthly compensation multiplied by the total credited service multiplied by a factor set by statute. These pension payments are funded by contributions made by both members employees and employers.

CONTRIBUTION RATES

Fiscal year 2022 – 2023. Effective July 1, 2022

	Pension & Health Insurance Benefit	Long Term Disability Income Plan	Total
Employee	12.03%	0.14%	12.17%
Employer	12.03%	0.14%	12.17%

LONG-TERM DISABILITY

In the event of a qualifying disability, ASRS administers a Long-Term Disability program. The program pays an eligible ASRS member two-thirds of their salary after a six-month waiting period (180 days).

ADDITIONAL RETIREMENT OPTIONS

457 Plan or 403(b) Plans

Other tax deferred retirement savings through a 457 Plan or a 403(b) Plan is available. Contact your payroll administrator at extension 8224 to learn more about preferred vendor listing.

Login Here



Benefit Payments



Member Education



Estimate Your Benefits



QUALITY OF LIFE

SICK LEAVE

Full-time employees are entitled to six (6) days of sick leave upon hire. Beginning with the seventh month of service, employees will earn additional sick leave at the rate of one (1) day per calendar month, and may accrue up to a maximum of one hundred (100) days.

VACATION LEAVE

Full-time employees accrue vacation leave each month at a rate determined by policy and length of service. Maximum vacation leave accrual shall be limited to two years earnings based on the length of the current employment contract. Vacation leave shall be earned and accrued in compliance with the following schedule.

TUITION EXEMPTION PRIVILEGE

Full-time employees are eligible for free tuition for themselves and their dependents. Part-time employees and their dependents are eligible for up to 6 credits.



Classifications	Vacation Leave			
Executive	Months of service	1 – xx		
	Days earned/month	1.83		
Administrative	Months of service	1 – xx		
	Days earned/month	1.83		
Management & Other Exempt	Months of service	1 – 36	37 – xx	
	Days earned / month	1.25	1.83	
Professional Staff	Months of service	1 – 60	61 – 120	120 – XX
	Days earned/month	1.00	1.66	1.83
Faculty contracted on the Faculty Salary Schedule to work the academic calendar including extra duty days	Vacation leave is not earned. Holidays are applicable as annually approved by the District Governing Board as part of the academic calendar.			

HOLIDAY LEAVE



Faculty holiday leave is designated per academic calendar and includes winter break and spring break. Staff holiday leave is authorized by policy and currently totals twenty two (22) days in a calendar year.

Holiday	2022	2023
New Year's Day	Monday, Jan. 3	Monday, Jan. 2
Martin Luther King Jr. Day	Monday, Jan. 17	Monday, Jan. 16
President's Day	Monday, Feb. 21	Monday, Feb. 20
Spring Break (5)	M-F, Mar. 14-18	M-F, Mar. 13-17
Memorial Day	Monday, May 30	Monday, May 29
Independence Day	Monday, Jul. 4	Tuesday, Jul. 4
Labor Day	Monday, Sept. 5	Monday, Sept. 4
Fair / Columbus Day	Friday, Oct. 7	Friday, Oct. 6
Veterans Day	Friday, Nov. 11	Friday, Nov. 10
Thanksgiving Day + (2)	W-F, Nov. 23-25	W-F, Nov. 22-24
Christmas Day + (5)	Dec. 23-30	Dec. 22-30
Total Authorized Holidays	22	22

ADDITIONAL BENEFITS

FINANCIAL INFORMATION, RESOURCES AND



Financial issues can arise at any time, from dealing with debt to saving for college. Our financial professionals are here to discuss your concerns and provide you with the tools and information you need to address your finances, including:

- Saving for college
- Retirement planning
- Getting out of debt
- Estate Planning
- Tax questions

EMPLOYEE ADMISSION TO COLLEGE EVENTS

Full time employees and their immediate families or companions are generally authorized to attend the following College-sponsored events free of charge, subject to specified exceptions.**

- EAC Intercollegiate Athletic Events
- EAC plays, concerts, musicals, club activities and other College-sponsored events

****Exceptions** There are some agreements with other groups, which expressly dictate differing admission policies to selected events (such as EAC's Holiday Basketball Tournament). For these approved exceptions, EAC employees who attend will be expected to pay the appropriate admission(s).

Certain EAC fund-raising activities may be College-sponsored, but since they are designated as "fundraisers" EAC employees may be requested to pay to attend.



EAP - CONFIDENTIAL COUNSELING AND ONLINE INFORMATION, TOOLS AND SERVICES

GuidanceResources® Online is your one stop for expert information to assist you with the issues that matter to you up to 3 visits per issue per year including:

- Depression
- Stress and Anxiety
- Marital and family conflicts
- Alcohol and Drug Abuse
- Job Pressures
- Grief and Loss

**AVAILABLE 24 HOURS A DAY,
7 DAYS A WEEK**

Call: 800-311-4327

Your company Web ID: GEN311

LEGAL INFORMATION, RESOURCES & CONSULTATION

When a legal issue arises, our attorneys are available to provide confidential support with practical, understandable information and assistance. If you require representation, you can also be referred to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call any time with legal issues including:

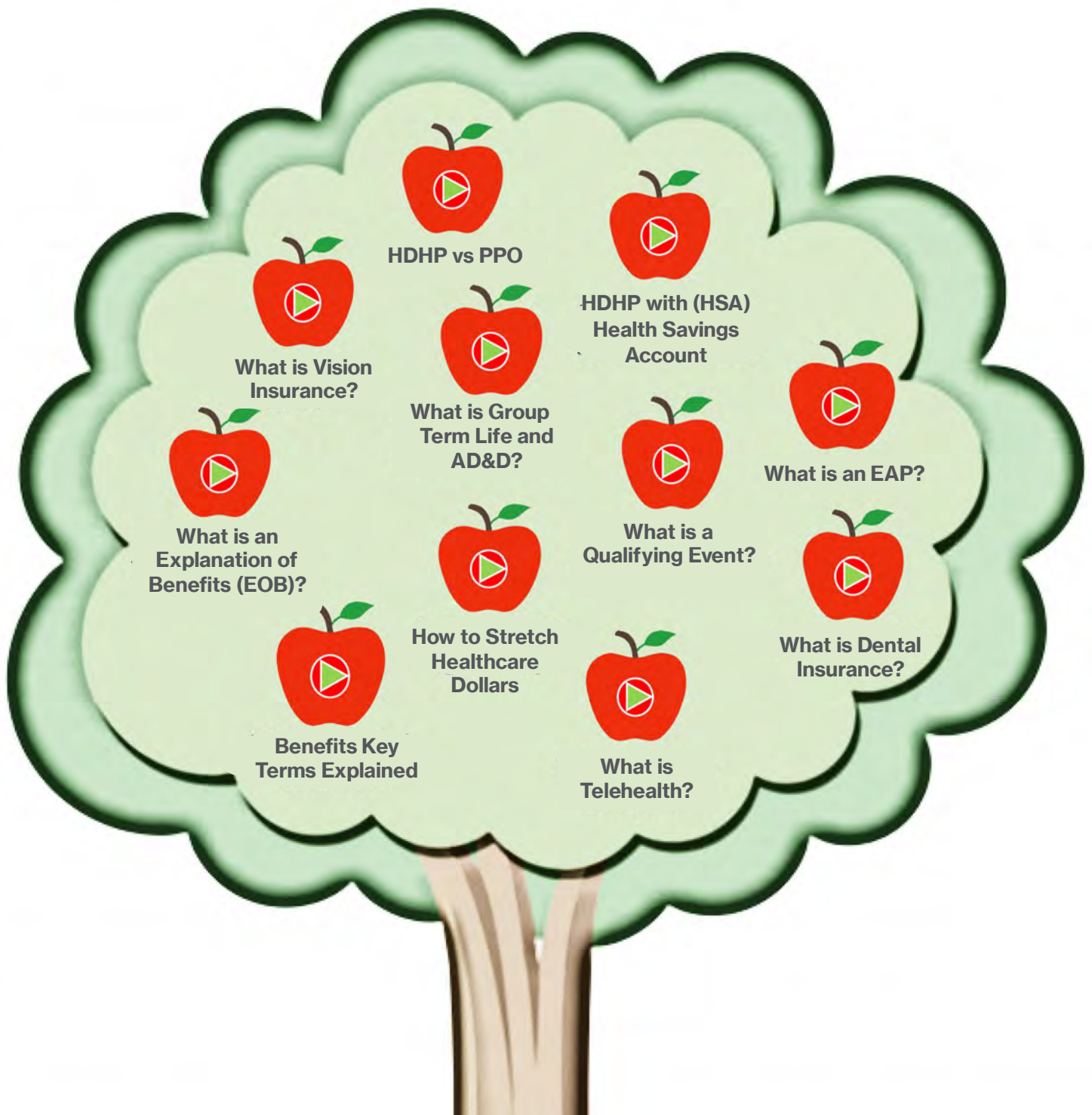
- Bankruptcy
- Criminal actions
- Landlord/tenant issues
- Civil lawsuits
- Debt obligations
- Real estate transactions
- Contracts
- Divorce and family law

COMPSYCH®

VIDEO RESOURCES



Select the links below to watch short educational videos about key benefits!



CONTACT INFORMATION AND ENROLLING

Medical – BlueCross BlueShield

App: MyBlue AZ
877.475.8440
www.azblue.com

Prescription – Optum Rx

800.356.3477
www.optumrx.com

Virtual Care – BlueCare Anywhere

www.bluecareanywhereaz.com

Dental – Delta Care

App: Delta Dental Mobile
800.352.6132
www.deltadentalaz.com

AZ State Retirement System

800.621.3778
www.azasrs.gov

Vision – VSP

App: VSP Vision
800.877.7195.6132
www.VSP.com

HSA – Health Equity

App: HealthEquity Mobile
866.346.5800
www.healthequity.com

Life, AD&D, STD – Prudential

888.778.2362
www.prudential.com

EAP - GuidanceResources

800.311.4327
www.guidanceresources.com
Company Web ID: GEN311

CBIZ – Claims Advocate

Angela Schlosser
520.321.7503
aschlosser@cbiz.com

CBIZ – Medicare

Michael Miller
520.321.7514
mmiller@cbiz.com

HOW TO MAKE MY BENEFIT ELECTIONS

1. Launch an Internet browser such as Internet Explorer.
2. Navigate to <https://workterra.net>
3. Enter the information below and click **Login**

Username: Employee ID
(Example: [999999])

Password: Full Last Name + last 4 of SSN
(Example: [Johnson9999])

Company: EAC

1. Update your password
2. Review and Confirm your and your families personal information
3. Select the benefit plans you wish to elect
4. After completing the elect or waive option for each offered benefit, you will come to the Confirmation Page. Review all elections for accuracy and print a copy of your confirmation by clicking the PDF button for download to save and print.
5. After confirming, select finish and you will be taken to your Employee Home Page.

Your Enrollment process is now complete.

**For further detailed
Instructions click here**



CBIZ Benefits & Insurance Services
1765 East Skyline Drive
Tucson, AZ 85718

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CBZ. All rights reserved.

This booklet is a snapshot of your benefits. Please refer to your full Benefit Summaries for additional details on all of your benefits. If there is any information in this booklet that contradicts the information in your Benefit Summaries or SBC's, the Benefit Summaries and SBC's will prevail.



2023 NORTHWEST FIRE DISTRICT EMPLOYEE BENEFITS GUIDE



2023 BENEFITS OVERVIEW

WELCOME TO 2023 BENEFITS OPEN ENROLLMENT

Northwest Fire District's annual insurance open enrollment period is about to begin.

We recognize the importance of benefits within the overall compensation package provided to all of our eligible employees. Northwest Fire District offers you and your family a comprehensive and valuable benefits package! To get the most out of your benefits—please review this Guide. This Guide is only a summary of our benefits. Please refer to actual plan documents for complete information. If there are differences between this Guide and the plan document, the plan document will prevail.

ENROLL ONLINE AT:

[HTTPS://ESS.TYLER-INC CODE.COM/NORTHWESTFIREDISTRICTAZ](https://ess.tyler-incode.com/northwestfiredistrictaz)

NOT SURE HOW TO GET STARTED? DON'T WORRY!

Prior to open enrollment, you will receive step-by-step enrollment instructions by email from our HR team.

Until then, now is the perfect time to prepare by doing the following:

- ✓ Check that your personal information is accurate at <https://ess.tyler-incode.com/northwestfiredistrictaz>
- ✓ Review the benefits in which you are currently enrolled,
- ✓ Take a look at the changes for 2023
- ✓ Check out the plans being offered for the coming year.

In this booklet, you'll find easy-to-understand instructions to help you make your benefit decisions.

As always, we value you as a member of the Northwest Fire District family and look forward to a healthy and safe 2023.

IMPORTANT DATES

Open enrollment runs
October 24th – November 4th

CHANGES & QUALIFYING EVENTS

Once you have enrolled, you cannot make changes to your benefits until the next open enrollment period, **UNLESS** you experience a "Qualifying Event," which includes:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in employment status or a change in coverage under another employer-sponsored plan, or certain government sponsored plans like Tricare.

If you qualify to change benefits, you must submit your request within the Employee Self Service Center within 30 days of the qualifying event. Documentation (such as birth certificate or marriage license) is required.

TIP

REMEMBER! Open enrollment is the one time of year you can make any adjustments you'd like for the upcoming plan year.

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CONTACT INFORMATION

If you have any questions regarding your benefits, you may contact your Northwest Fire District Human Resources Representative or the respective plan carrier.

MEDICAL INSURANCE

United HealthCare
www.uhc.com
(866) 734-7679

DENTAL INSURANCE

United HealthCare
www.uhc.com
(800) 244-6224

VISION INSURANCE

VSP
www.vsp.com
(800) 877-7195

LIFE, AD&D & DISABILITY INSURANCE

The Standard
www.standard.com
(800) 368-2859

BUSINESS TRAVEL ACCIDENT INSURANCE

The Hartford
www.thehartford.com
(866) 311-1559

RETIREMENT PLAN

Nationwide - Klark Krauter
krautek@nationwide.com
(520) 262-0348

FLEXIBLE SPENDING/HEALTH SAVINGS ACCOUNTS

WEX
www.wexinc.com
(800) 492-0669

YOUR HR BENEFITS TEAM

Northwest Fire District
HR@nwfdaz.gov
(520) 887-1010 Ext. 4747

CBIZ REPRESENTATIVE

Claims Resolution - Angela Schlosser
aschlosser@cbiz.com
(520) 321-7503



Throughout this guide you will find video and link icons that will take you to resources that provide additional information on the benefits available to you.

MEDICAL INSURANCE

YOUR HEALTH PLAN OPTION

As a full-time employee of Northwest Fire District, you may enroll in the United Healthcare Choice Plus High Deductible Plan (HDHP) paired with a Health Savings Account (HSA).

If you do not qualify to participate in a Health Savings Account (HSA), you may enroll in the HDHP with a Health Reimbursement Account (HRA).

**Your deductible will run from
JANUARY 1 – DECEMBER 31.**

While you have the option of using out-of-network providers, you can save money by using in-network providers because United Healthcare has negotiated significant discounts with them. If you choose to go out-of-network, you'll be responsible for the difference between the actual charge and United Healthcare UCR (Usual, Customary and Reasonable) charge, plus your out-of-network deductible and coinsurance.

With the Choice Plus HDHP, you should establish a Health Savings Account with WEX and contribute a portion of your paycheck into the account pre-tax. These funds can be used to cover medical expenses, including deductibles, and they're yours forever – even if you leave Northwest Fire District. And unlike a Flexible Spending Account (FSA), they are not forfeited at the end of each year.

TIP Get the most out of your benefit plans by using in-network providers.

FREQUENTLY ASKED QUESTIONS

? How many hours do I need to work to be eligible for insurance benefits?

You must be a full-time employee working a minimum of 30 hours per week on a regular basis.

? Will I receive a new Medical ID card?

You will receive an ID card and an HSA card in the mail if you are electing medical coverage.

? Can I enroll family members?

You can enroll your legal spouse, your child(ren), or spouse's child(ren) up to age 26.

? How long can I cover my dependent children?

Dependent children are eligible until the end of the month in which they turn age 26.

? I just got hired. When will my benefits become effective?

Your medical insurance benefit will begin on the 1st of the month following thirty (30) days of employment for regular full-time employees.

HOW TO GET STARTED

REVIEW YOUR MEDICAL PLAN

■ CHOICE PLUS HDHP WITH HSA

CHOICE PLUS HDHP WITH HSA

OFFERS SEVERAL BENEFITS:

- No premium and low potential maximum out-of-pocket expenses
- Routine preventive exams are covered at 100%
- Broad network of providers available
- The HSA is owned by you
- You have more control over your health care dollars

▶ HDHP With HSA Overview



MEDICAL INSURANCE

United Healthcare	Choice Plus HDHP with HSA
	Employee Cost Per Paycheck
Employee Employee + Spouse Employee + Child(ren) Employee + Family	\$0 \$0 \$0 \$0
	In-Network
Deductible Individual / Family	\$1,500 / \$3,000
Coinsurance (Member Pays)	0%
Out-of-Pocket Maximum Individual / Family	\$2,200 / \$4,400
Office Visits Preventative Care Primary Care Physician / Specialist Diagnostic Lab / X-Ray Urgent Care	Covered at 100% Deductible then 0% Deductible then 0% Deductible then 0%
Hospital Visits Inpatient Care (Facility / Physician) Outpatient Surgery Major Diagnostics & Imaging Emergency Room	Deductible then 0% Deductible then 0% Deductible then 0% Deductible then 0%
Prescription Drug Deductible Retail Tier 1 / 2 / 3 / 4 Copay Mail Order (90-day supply)	Applies, then: \$15 / \$35 / \$55 \$37.50 / \$87.50 / \$137.50
	Out-of-Network
Deductible Individual / Family	\$2,250 / \$4,500
Coinsurance (Member Pays)	20%
Out-of-Pocket Maximum Individual / Family	\$6,600 / \$13,200

(1) If more than one person in a family is covered under the Plan, the single coverage Annual Deductible stated above does not apply. For Family coverage, the family Annual Family Deductible is \$2,800. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.

(2) Out-of-Pocket maximum includes all cost-sharing: deductible, coinsurance and copays

(3) All Out-of-Network services subject to deductible, coinsurance and balance billing

Premiums can be withheld from your paycheck on a pre-tax basis for Medical, Dental, and Vision insurance. Based upon your individual tax bracket, this could save you a considerable amount of money.

Your election can only be changed during the plan year if you experience a qualifying life status change. You must notify Human Resources within 30 days of the event.

Plans are detailed in United Healthcare's 2023 Certificate of Coverage (COC). This is a brief summary only. For exact terms and conditions, please refer to your certificate.

PHARMACY & WELLNESS



OPTUM RX

Optum Rx is your plan's pharmacy care services manager and will administer the prescription drug plan for Northwest Fire District. Get the most out of your pharmacy plan. The more you know, the more you can save. Visit optumrx.com today!



Optum Rx Home Delivery

Order up to a 90-day supply of the medication you take regularly for less. There is no charge for standard shipping to U.S. addresses.

Set up home delivery online, with the app or by calling OptumRx.

While on the go

Access your pharmacy benefit and manage your prescriptions from your smartphone or tablet with the OptumRx app.² When you use the app you can:

- Refill or renew home delivery prescriptions
- Transfer a retail prescription to home delivery
- View your prescription claims history or order status
- Locate a pharmacy
- Display ID card



Website home page

Log in to optumrx.com with your user name and password or register, to view general health information.

Visit optumrx.com for information to help you better understand and manage your medications. It's safe and secure.

Website features and tools

Once registered on our website, you will be able to:

- Fill new prescriptions via home delivery from OptumRx®
- Search for drug prices and lower-cost alternatives
- Refill and renew home delivery prescriptions
- Transfer retail prescriptions to home delivery from OptumRx
- View order status and claim history
- Sign up for medication and refill reminders via text message
- View your real time benefits

UHC RALLY PROGRAM

Personalized health recommendations, just for you.

- Rally is designed to help you make changes to your daily routine, set smart goals and track your progress. You'll get personalized recommendations to help you move more, eat better and improve your health—and have fun doing it.
- Start with the quick Health Survey and get your Rally AgeSM, a measure to help you assess your overall health. Rally will then recommend missions for you: activities designed to help improve your diet, fitness and mood. Start easy, and level up when you're ready.
- Plus, on Rally there are lots of ways to earn Rally Coins, which you can use for chances to win rewards. Rack up Rally Coins for taking healthy actions, like joining missions, completing healthy activities, or pushing yourself in a Challenge.

Rally is available at no additional cost to you, as part of your health plan benefits.

RALLY®



UnitedHealthcare®



GET STARTED TODAY
AT [MYUHC.COM](https://myuhc.com)



Get Your Rally Age



Win Cool Stuff



Build Healthy Habits

CARE OPTIONS & WHEN TO USE THEM

YOUR CARE OPTIONS

While we recommend that you seek routine medical care from your primary care physician whenever possible, there are alternatives available to you. Services may vary, so it's a good idea to visit the care provider's website. Be sure to check that the facility is in-network by calling the toll-free number on the back of your medical ID card, or by visiting www.myuhc.com.



PRIMARY CARE

- Routine, primary/preventive care
- Non-urgent treatment
- Chronic disease management

For routine, primary/ preventive care or non-urgent treatment, we recommend going to your doctor's office. Your doctor knows you and your health history and has access to your medical records. You may also pay the least amount out of pocket.



VIRTUAL VISITS

- Cold/flu
- Headache
- Fever
- Eye infections
- Sinus problems

Virtual Visits let you see and talk to a doctor from your mobile device or computer without an appointment, anytime and anywhere! United HealthCare partners with multiple providers to bring you care from the comfort and convenience of your home or wherever you are.



CONVENIENCE CARE

- Common infections (ear infections, pink eye, strep throat & bronchitis)
- Flu shots
- Minor injuries
- Vaccines
- Rashes
- Screenings

These providers are a good alternative when you are not able to get to your doctor's office and your condition is not urgent or an emergency. They are often located in malls or retail stores (such as CVS, Walgreens, Wal-Mart and Target), and generally serve patients 18 months of age or older without an appointment. Services may be provided at a lower out-of-pocket cost than an urgent care center.



URGENT CARE

- Sprains
- Respiratory conditions
- Minor infections
- Sore throats
- Stomach (pain, vomiting, diarrhea)
- Back pain

Sometimes you need medical care fast, but a trip to the emergency room may not be necessary. During office hours, you may be able to go to your doctor's office. Outside regular office hours – or if you can't be seen by your doctor immediately – you may consider going to an Urgent Care Center where you can generally be treated for many minor medical problems faster than at an emergency room.



EMERGENCY ROOM

- Heavy bleeding
- Large open wounds
- Chest pain
- Spinal injuries
- Difficulty breathing
- Major burns
- Severe head injuries

An emergency medical condition is any condition (including severe pain) which you believe that, without immediate medical care, may result in serious injury or is life threatening. Emergency services are always considered in-network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once your condition has been stabilized.

If you believe you are experiencing a medical emergency, go to the nearest emergency room or call **9-1-1**, even if your symptoms are not described here.



Primary Care vs. Urgent Care vs. ER

UNITED HEALTHCARE



UNITED HEALTHCARE MEMBER APP AND PORTAL

Put your medical & pharmacy coverage at your fingertips. Your personalized website myuhc.com features tools designed to help you:

- Find, price and save on care — you may save an average of 36%** when you compare costs for providers and services in your network
- Get care from anywhere with Virtual Visits.*** A doctor can diagnose common conditions by phone or video 24/7.
- Understand your benefits and the financial impact of care decisions
- Find tailored recommendations regarding providers, products and services. You can even generate an out-of-pocket estimate based on your specific health plan status.
- Access claim details, plan balances and your health plan ID card quickly
- Follow through on clinical recommendations and access wellness programs
- Order prescription refills, get estimates and compare medication pricing
- Check your plan balances, access financial accounts and more

**Download the
UnitedHealthcare® app**
It's perfect for on-the-go access to help you find a nearby doctor and more.



Registering is quick. Go to myuhc.com



UNITED HEALTHCARE VIRTUAL VISITS

A Virtual Visit lets you see and talk to a doctor from your mobile device or computer without an appointment. When your PCP is not available, if you become ill while traveling or you're considering visiting a hospital ER for a non-emergency condition, you could use Virtual Visits.

Doctors can treat a wide range of health conditions — including many of the same conditions as an emergency room (ER) or urgent care —and may even prescribe medications,² if needed. **With a United Healthcare plan, your cost for a 24/7 Virtual Visit is usually \$49 or less.³**



Conditions commonly treated through a virtual visit:

■ Allergies	■ Cold/flu	■ Pink eye
■ Bladder infection/ urinary tract infection	■ Diarrhea	■ Rash
■ Bronchitis	■ Migraine/ headaches	■ Sinus problems
		■ Sore throat

Most visits take about 10-15 minutes, and your doctor can write a prescription, if needed, that you can pick up at your local pharmacy.

To access Virtual Visits, log into myuhc.com® and choose from provider sites where you can register for a Virtual Visit. After registering and requesting a visit, you will pay your portion of the service costs according to your medical plan, and then you will enter a virtual waiting room.

GET STARTED

Sign in at myuhc.com/virtualvisits | Call 1-855-615-8335
Download the UnitedHealthcare app

HEALTH SAVINGS ACCOUNT (HSA)



UNDERSTANDING A HEALTH SAVINGS ACCOUNT (HSA)

THERE ARE TWO WAYS YOU CAN PUT MONEY INTO YOUR HSA:

- Regular payroll deductions on a pre-tax basis, and
- Lump-sum contributions of any amount, anytime, up to the maximum limit.

WHAT IS AN HSA?

A savings account where you can either direct pre-tax payroll deductions or deposit money to be used to pay for current or future qualified medical expenses for you and/or your dependents. Once money goes into the account, it's yours to keep — the HSA is owned by you, just like a personal checking or savings account.

THE HSA CAN ALSO BE AN INVESTMENT OPPORTUNITY.

Depending upon your HSA account balance, your account can grow tax-free in an investment of your choice (like an interest-bearing savings account, a money market account, a wide variety of mutual funds — or all three). Of course, your funds are always available if you need them for qualified health care expenses.

YOUR FUNDS CAN CARRY OVER AND EVEN GROW OVER TIME.

The money always belongs to you, even if you leave the company, and unused funds carry over from year to year. You never have to worry about losing your money. That means if you don't use a lot of health care services now, your HSA funds will be there if you need them in the future — even after retirement.

HSA FUNDS CAN BE USED FOR YOUR FAMILY.

You can use your HSA for your spouse and tax dependents for their eligible expenses — even if they're not covered by your medical plan. You can pay for or reimburse yourself from your HSA account for the cost of medically necessary services and supplies.

Contribute up to \$3,850 Single, or \$7,750 Family.
This includes your \$925 contribution from Northwest Fire District

WHAT ARE THE RULES?

- You must be covered under a Qualified High Deductible Health plan (QHDHP) in order to establish an HSA.
- You cannot establish an HSA if you or your spouse also have a medical FSA, unless it is a Limited Purpose FSA.
- You cannot be enrolled in Medicare or TRICARE due to age or disability.
- You cannot set up an HSA if you have insurance coverage under another plan, for example your spouse's employer, unless that secondary coverage is also a qualified high deductible health plan.
- You cannot be claimed as a dependent under someone else's tax return.

WHAT ELSE SHOULD I KNOW?

- You can invest up to the IRS's annual contribution limit. Contributions are based on a calendar year. The contribution limits for 2023 are \$3,850 for Single and \$7,750 for Family coverage. If you're age 55 or older, you are allowed to make an extra \$1,000 contribution each year.
- The contributions grow tax-free and come out tax-free as long as you utilize the funds for approved services based on the IRS Publication 502.
- If you use the money for non-qualified expenses, then the money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- There is no penalty for distributions following death, disability (as defined in IRC 72), or attainment of Medicare eligibility age, but taxes would apply for non-qualified distributions.
- Once you meet your in-network deductible on this plan, the plan pay 100% of in-network covered medical expenses and you pay prescription drug copays until you reach your out of pocket max for the calendar year.
- If your healthcare expenses are more than your HSA balance, you need to pay the remaining cost another way, such as a credit card or personal check. But save your receipts in case you are ever audited! You can request reimbursement later, after you have accumulated more money in your account.

HEALTH SAVINGS ACCOUNT (HSA)

YOU CAN USE HSA FUNDS FOR IRS-APPROVED ITEMS SUCH AS:

- Doctor's office visits
- Dental services
- Eye exams, eyeglasses, laser surgery, contact lenses and solution
- Hearing aids
- Orthodontia, dental cleanings, and fillings
- Prescription drugs and some over-the-counter medications (such as allergy medicine, cold and flu, pain relievers, and feminine hygiene)
- Physical therapy, speech therapy, and chiropractic expenses

More information about approved items, plus additional details about the HSA, is available at [irs.gov](https://www.irs.gov).

Every time you use your HSA, save your receipt in case the IRS asks you to prove your claim was for a qualified expense. If you use HSA funds for a non-qualified expense, you will pay tax and a penalty on those funds.

The HSA is your personal account and contains your personal funds. It can be considered an asset by a creditor and garnished as applicable.

As an HSA account holder, you will be required to file a Form 8889 with the IRS each year. This form identifies any contributions, distributions, or earned interest associated with your account.

FREQUENTLY ASKED QUESTIONS

WHAT WILL I PAY AT THE PHARMACY WITH THE HSA QUALIFIED PLAN OPTIONS?

You will pay the actual discounted cost of the drug until you satisfy your calendar year deductible in full.

WHAT WILL I PAY AT THE PHYSICIAN'S OFFICE WITH THE HSA QUALIFIED PLAN?

You'll provide your ID card at the time of the visit and the physician's office will submit the claim to United Healthcare.

You will not owe anything at the time of the visit. Later you'll receive an Explanation of Benefits (EOB) from United Healthcare that shows the charges discounted based on their contract with the physician. When you receive a bill from the physician's office, you pay the portion of the discounted cost you are responsible for as shown on the EOB.

WHERE CAN I GET A COPY OF AN EOB?

You can access all of your EOB information, as well as obtain other important information, by logging on to myuhc.com.

▶ **HSA vs. FSA**

FLEXIBLE SPENDING ACCOUNTS (FSA)



HEALTH CARE FLEXIBLE SPENDING ACCOUNT

This account enables you to pay medical, dental, vision, and prescription drug expenses that may or may not be covered under your insurance program (or your spouse's) with pre-tax dollars. You can also pay for dependent health care, even if you choose single (vs. family) coverage. The total amount of your annual election is available to you up front, reducing the chance of having a large out-of-pocket expense early in the plan year. Be aware – any unused portion of the account at the end of the plan year is forfeited.

Eligible Expenses Examples

■ Coinsurance and copayments	■ Licensed practical nurses
■ Contraceptives	■ Orthopedic shoes
■ Dental expenses	■ Oxygen
■ Deductible amounts	■ Psychiatric care
■ Eyeglasses, including exam fee	■ Psychologist expenses
■ Hearing devices and batteries	■ Routine physical
■ Laboratory fees	■ Hospital bills

HOW THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT WORKS

When you have out-of-pocket expenses (such as copayments and deductibles), you can either use your FSA debit card to pay for these expenses at qualified providers or submit an FSA claim form with your receipt to WEX. Reimbursement is issued to you through direct deposit into your bank account, or if you prefer, a check can be issued to you.

2023 Maximum Contributions

Health Care FSA	\$3,050 max
Dependent Care FSA	\$5,000 max
Limited Purpose FSA	\$2,850 max

LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT

This account works just like a regular FSA, but can only be used for eligible dental and vision expenses. **If you are enrolled in an HSA, you may ONLY enroll in a limited purpose FSA.**

SELECT YOUR FSA ACCOUNTS

- HEALTH CARE FSA
- DEPENDENT FSA
- LIMITED PURPOSE FSA



DEPENDENT CARE EXPENSE ACCOUNT

This account gives you the opportunity to redirect a portion of your annual pay on a pre-tax basis to pay for dependent care expenses. An eligible dependent is any member of your household for whom you can claim expenses on your Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses." Children must be under age 13. Care centers which qualify include dependent care centers, preschool educational institutions, and qualified individuals (as long as the caregiver is not a family member and reports income for tax purposes). Before deciding to use the Dependent Care Expense Account, it would be wise to compare its tax benefit to that of claiming a child care tax credit when filing your tax return. You may want to check with your tax advisor to determine which method is best for you and your family. Any unused portion of your account balance at the end of the plan year is forfeited.

CONTACT INFORMATION

Request a full statement of your accounts at any time by calling 800-492-0669, or log on to www.wexinc.com/login/benefits-login/ to review your FSA balance.



What Is A Flexible Spending Account?



Click here for a list of some of the Healthcare FSA Eligible Expenses

DENTAL INSURANCE

REVIEW AND SELECT YOUR DENTAL PLAN



**UNITED HEALTHCARE YOUR
DENTAL CARRIER FOR 2023.**

You have two dental plans to choose from. The PPO Plan offers coverage in and out-of-network. It is to your advantage to utilize a network dentist in order to achieve the greatest cost savings. If you choose to go out-of-network, you will be responsible for any cost exceeding United Healthcare's negotiated fees, plus any deductible and coinsurance associated with your procedure.

The DHMO Plan provides in network coverage only.

Dependent children are eligible until the end of the month in which they turn age 26.

DENTAL INSURANCE PLAN OPTIONS AND COSTS

United HealthCare	Employee Cost Per Paycheck		and cannot balance bill you. Out-of-Network Providers: Provider is reimbursed based on Reasonable and Customary standards and balance billing is possible.	
	UHC DPPO Plan			UHC DHMO
Employee	\$0			\$0
Employee + Spouse	\$16.41			\$0
Employee + Child(ren)	\$19.99			\$0
Employee + Family	\$42.41		\$0	
	In-Network	Out-of-Network		
Deductible Individual / Family	\$50 / \$150		Refer to the UHC DHMO Fee Schedule for Benefits	
Annual Maximum	\$5,000			
	Carrier Pays			
Diagnostic / Preventive Services	100%	80%	Refer to the UHC DHMO Fee Schedule for Benefits	
Basic Services	80%	70%		
Major Services	50%	40%		
Orthodontia Services	50% up to the \$1,000 lifetime maximum			

DPPO PLAN

In-Network Providers:
Provider is reimbursed based on contracted fees and cannot balance bill you.

Out-of-Network Providers:
Provider is reimbursed based on Reasonable and Customary standards and balance billing is possible.

FIND A DENTAL PROVIDER



What Is Dental Insurance?

To find a United HealthCare Dental Provider in your area, visit the website at www.myuhc.com

- Click "Find a Dentist" then click the "Employer and Individual Plans" button
- Type in your street address, city & state or ZIP code then click the blue "Continue" button
- Select your dental plan network from the list National Options PPO 30 (PPO Plan) or National Select Managed Care (DHMO Plan)
- Search for providers and services or find care by category



VSP IS YOUR VISION CARRIER FOR 2023.

The vision plan offers coverage both in-network and out-of-network. It is to your advantage to utilize a network provider in order to achieve the greatest cost savings. If you go out-of-network, your benefit is based on a reimbursement schedule.

Also, if you are considering Lasik surgery or other non-covered benefits, there are discounts available with some providers. To find a participating provider, go to www.vsp.com.



What Is Vision Insurance?

VISION INSURANCE PLAN OPTIONS AND COSTS

VSP	Employee Cost Per Paycheck	
Employee	\$0	
Employee + Spouse	\$1.42	
Employee + Child(ren)	\$1.53	
Employee + Family	\$4.92	
	In-Network	Out-of-Network
Examination Copay	\$10 copay	<u>Reimbursement</u> Up to \$45
Frequency of Service	ONCE EVERY PLAN YEAR ONCE EVERY PLAN YEAR ONCE EVERY PLAN YEAR	
Exam		
Lenses		
Single	\$10 copay; 100% covered	<u>Reimbursement</u> Up to \$30
Bifocal	\$10 copay; 100% covered	Up to \$50
Trifocal	\$10 copay; 100% covered	Up to \$65
Lenticular	\$10 copay; 100% covered	Up to \$100
Frames	\$10 copay; \$130 allowance, 20% off balance over \$130	<u>Reimbursement</u> Up to \$70
Conventional Contacts	Up to \$60 copay; \$130 allowance, 15% off balance over \$150	<u>Reimbursement</u> Up to \$105
Medically Necessary Contacts	\$10 copay, paid-in-full	<u>Reimbursement</u> Up to \$210

FIND A VISION PROVIDER

To find a VSP Vision Provider in your area, visit the website at www.vsp.com or call 800-877-7195.

- Click “Find A Doctor”. To ensure you see an in-network eye doctor for your plan, create an account or log in before you search.
- Type in your ZIP Code or City and State then click the blue “Search” button
- Choose a provider from the list, or narrow your search further using the “Advances Search +” link on the right-hand side of the page to narrow results by Distance, Frame Brand, Language, Services, Products, etc.

LIFE AND AD&D INSURANCE



BASIC LIFE INSURANCE—STANDARD

Eligible fulltime employees are provided \$50,000 of employer paid life insurance on or off duty. Eligible full-time employees are also covered with \$250,000 of Accidental Death & Dismemberment Travel coverage. This provides additional payments to you when you become ill or injured while on duty.

VOLUNTARY LIFE AND DEPENDENT LIFE INSURANCE

You can purchase additional Life and AD&D Coverage beyond what Northwest Fire District provides. The Standard guarantees issues coverage during your initial enrollment period – which means you can't be turned down for coverage based on medical history.

- **Voluntary Employee Life:** minimum \$10,000 to a maximum of \$300,000, in \$10,000 increments. Guarantee issue up to \$80,000.
- **Optional Spouse Life:** minimum \$10,000 up to 100% of the employee amount, to \$300,000 maximum in \$5,000 increments. Guarantee issue up to \$10,000.
- **Optional Child Life:** minimum \$2,000 up to \$10,000 maximum. Can cover all your children. Guarantee issue up to \$10,000. Maximum \$500 for children under 6 months. Employee election is required.

You must be enrolled in voluntary life and/or ADA& life coverage in order for your spouse, and/or eligible dependent children to enroll.

AD&D INSURANCE What Is Life & AD&D?

- **AD&D for you:** Up to a maximum \$500,000 or 5x your annual earnings in \$25,000 increments. Your benefits will reduce to 65% at age 70, 45% at age 75, 30% at age 80, 20% at age 85, 15% at age 90 and 10% at age 95.
- **AD&D for your family:** Spouse maximum of \$250,000; 50% of the employee benefit if no children; 40% of the employee benefit if eligible children. Child maximum of \$10,000; 10% of the employee benefit for children if eligible spouse; 15% of the employee benefit for children if not.

WHEN EVIDENCE OF INSURABILITY IS REQUIRED

- If you don't enroll in the Voluntary Life during your initial enrollment period, you'll be required to complete an Evidence of Insurability form and be approved by The Standard before you're able to get coverage in the future.
- For reinstatements if required.
- For Members and Dependents eligible but not insured under the Prior Plan.
- For any Benefit in excess of the Guarantee Issue Amounts.
- For any increase resulting from a plan or option change elect.



EOI Brochure

REVIEW YOUR LIFE INSURANCE POLICY

- ADD YOUR SPOUSE
- ADD YOUR DEPENDENTS
- INCREASE YOUR COVERAGE

OPTIONS AND COSTS PER PAY PERIOD

The Standard	Rates per \$1,000 of coverage		
	Age	Employee	Spouse
Voluntary Life	<20	\$0.045	\$0.045
	20-34	\$0.063	\$0.063
	35-39	\$0.081	\$0.081
	40-44	\$0.108	\$0.108
	45-49	\$0.171	\$0.171
	50-54	\$0.270	\$0.270
	55-59	\$0.432	\$0.432
	60-64	\$0.648	\$0.648
	65-69	\$1.098	\$1.098
	70-74	\$1.953	\$1.953
	75+	\$4.680	
	Child(ren)	\$0.20	
Voluntary AD&D Per \$1,000	\$0.045 \$.068 for family		

Premium for these coverages will be calculated within the online Employee Self Service portal.

To calculate your per pay period premium (24 pay periods) for supplemental life coverage, the below steps should be followed. For spouse supplemental life, use your spouse's age. Employee supplemental life benefit amount must be in increments of \$10,000 and spouse supplemental life benefit amount must be in increments of \$5,000.

Calculate Monthly Premium:

Monthly Premium = \$____ (rate based upon age) / 1000 x ____ (benefit amount)

Calculate Per Pay Period (26) Premium:

Monthly Premium x 12 / 26



[Click here to get started with Evidence of Insurability](#)

DISABILITY & TRAVEL INSURANCE



SHORT-TERM DISABILITY INSURANCE

Short-Term Disability insurance is offered through The Standard. Northwest Fire District pays 100% of the premium cost. The plan benefit is 70% of basic weekly earnings up to a maximum of \$1,000 per week.

Benefits are paid after a waiting period of 30 days for an accident and 30 days for sickness. Benefits can continue for up to 22 weeks for accident and sickness.



What Is Disability Insurance?



SUPPORT SERVICES FOR SAFE TRAVEL BUSINESS TRAVEL ACCIDENT (BTA) INSURANCE

Business Travel Accident insurance is offered through The Hartford. While traveling on a trip covered under an Accident & Health policy from The Hartford, you can feel confident that you're in safe hands. Partnering with International Medical Group (IMG), a leading global assistance provider, you have 24/7 access to medical and travel assistance anywhere in the world.

WHAT DO I DO FIRST?

In the event of a life-threatening emergency, call the local emergency authorities first to receive immediate assistance, and then contact IMG.

INTERNATIONAL MEDICAL GROUP (IMG) CONTACT INFORMATION

Policyholder Name: Northwest Fire District
Policy Plan #: 59-GTA-101473
Policy Effective Date: 1/1/2021
U.S. and Canada: 866-311-1559 (toll-free)
Outside U.S.: 240-330-1359 (collect call)
assist@imglobal.com

TRAVEL INTELLIGENCE APP

As part of your insurance solutions with The Hartford, you can access *TravelKit*, the IMG Travel Intelligence app. Travelers will have unlimited access to information about medical, travel and security risks wherever they are in the world.

REVIEW YOUR DISABILITY AND TRAVEL COVERAGE

- SHORT-TERM DISABILITY
- BUSINESS TRAVEL ACCIDENT INSURANCE

COULD YOU PAY THE BILLS IF YOU WEREN'T WORKING?

Less than **1/4** of U.S. consumers have enough emergency savings to cover six months or more of their expenses.

DOWNLOAD AND REGISTER FOR THE TRAVEL INTELLIGENCE APP

- Before your next trip, search and download *TravelKit* in your mobile app store
- Register with code HIGBTA



VOLUNTARY COVERAGES



CRITICAL ILLNESS INSURANCE

While it is impossible to prepare for the physical and emotional consequences of being diagnosed with a critical illness, you can prepare for the consequences such an illness may have on your personal finances. You have the option to enroll in Critical Illness Protection through TransAmerica.

This Critical Illness insurance policy can help with the treatment costs of a covered critical illnesses – such as a heart attack or stroke. More importantly, it can help you focus on recuperation instead of the distraction of out-of-pocket costs.

CRITICAL ILLNESS BENEFIT PAYABLE FOR:

- Invasive Cancer
- Stroke
- Bone Marrow Transplant
- Heart Attack
- Major organ transplant
- End Stage Renal Failure

HOW CRITICAL ILLNESS COVERAGE WORKS



ACCIDENT INSURANCE

You have the option to enroll in Accident Insurance through TransAmerica. You can choose from three different tiers of coverage. In the event of a covered accident, the plan pays you cash benefits to help you pay for the costs associated with out-of-pocket expenses and bills – expenses major medical may not take care of.

TRANSAMERICA ACCIDENT INSURANCE COVERS THINGS LIKE THE FOLLOWING:

- Ambulance rides
- Wheelchairs, crutches, and other medical appliances
- Surgery and anesthesia

CONTACT NATIONAL BENEFITS CONSULTANTS, INC. (NBC) FOR ALL CORRESPONDENCE RELATED TO YOUR ACCIDENT AND CRITICAL ILLNESS COVERAGE

- ◆ Toll-Free: 888-622-5558
- ◆ Fax: 480-940-1511
- ◆ www.nbcbenefits.com
- ◆ enroll@nbcbenefits.com

PROTECT YOUR FINANCES

- CRITICAL ILLNESS COVERAGE
- ACCIDENT INSURANCE



What is Critical Illness Insurance?

RETIREMENT



OUR 457(B) PLAN IS MANAGED BY NATIONWIDE

If you are participating in contributions to a District-sponsored Health Savings Account (HAS) and/or Deferred Compensation 457(b) Plan, remember that these benefits are regulated by the Internal Revenue Service (IRS) and have a maximum contribution limit each calendar year. Contributions in excess of the IRS annual contribution limits are not tax deferred and are generally subject to income tax liability and penalties.

The District cannot provide you with tax or financial planning advice. You are strongly encouraged to consult with your tax advisor(s) and financial planner(s) to determine which plans and contribution amounts are most advantageous for your circumstances, and any tax implications of these plans.

ARS NATIONWIDE 457(B) ANNUAL LIMITS

For calendar year 2023, those participating in a 457(b) plan may contribute up to \$20,500. In addition, those participants who are 50 or older may contribute an extra \$6,500 as a “catch-up” contribution. Employees eligible for “catch-up” contributions in the 457(b) plan may contact **Klark Krauter** at (520) 262-0348, customer service at (800) 669-7400, email at krautek@nationwide.com to discuss available options and for questions regarding calculating plan year deductions, recalculating deductions due to a one-time contribution (PTO Payout) or 457(b) “catch-up” contributions.

TIPS ON HOW TO SAVE SMART FOR RETIREMENT:

- Start **NOW**. Don't wait. Time is critical.
- Start small, if necessary. Even small contributions can make a big difference given enough time and the right kind of investments.
- Save regularly. Make saving for retirement a habit.
- Be realistic about investment returns. Never assume that a year or two of high market returns (or market declines) will continue indefinitely.
- Don't dip into retirement savings.

RETIREMENT

■ YOUR 457(B) PLAN



What are the advantages of participating in a 457(b) plan?

- Contributions to a 457(b) plan are tax-deferred.
- Earnings on the retirement money are tax-deferred.

EMPLOYEE ASSISTANCE PROGRAM



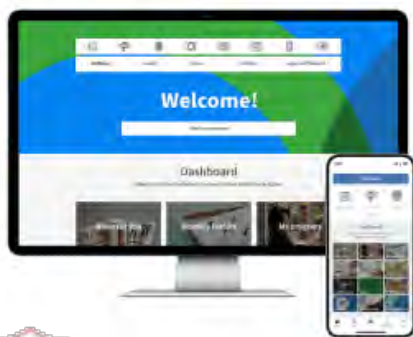
RESOURCES FOR EVERYONE

Mental health includes your emotional, psychological, and social well-being. It can affect how you think, feel, and act. It also determines how you handle stress, relate to others, and make healthy life choices. Northwest Fire District understands the importance of your mental health and offers the following resources:

SUPPORTLINC EAP

Provided at no cost to you, SupportLinc employee assistance program offers services to help promote well-being and enhance the quality of life for you and your family. If you are experiencing stress, having financial difficulties, struggling at work or home, please call 1-888-881-5462 to speak with someone 24/7. Available online too at:

<https://nwfdaz.mysupportportal.com/>



Your web portal and mobile app

- The one-stop shop for program services, information and more.
- Discover on-demand training to boost wellbeing and life balance.
- Find search engines, financial calculators and career resources.
- Explore thousands of articles, tip sheets, self-assessments and videos.

SHORT-TERM COUNSELING

Access up to twelve (12) counseling sessions per incident, in-person or via video, to resolve stress, depression, anxiety, work-related pressures, relationship issue or substance abuse.

We understand how challenging it can be to balance your work and personal life, and we are committed to helping you do just that.

Convenient, on-the-go support

- **Textcoach®**
Personalized coaching with a licensed counselor on mobile or desktop.
- **Animo**
Self-guided resources to improve focus, wellbeing and emotional fitness.
- **Virtual Support Connect**
Moderated group support sessions on an anonymous, chat-based platform



Fire and EMS professionals are exposed to potentially traumatic calls on nearly every shift. Nationwide, firefighters overwhelmingly report job-related stress has affected their mental health—yet more than 80% of firefighters say they fear being seen as weak or unfit for duty if they ask for help for emotional or behavioral issues.



Cordico's wellness solution addresses these challenges, providing firefighters and their family members with on-demand access to relevant, trusted and effective wellness resources. The fire and rescue wellness app offers a complete range of self-assessments as well as continuously updated videos, guides and courses on more than 60 behavioral health topics—all designed specifically for first responders.

TRUSTED, TAILORED BEHAVIORAL HEALTH SUPPORT

Cordico's wellness tools and self-assessments are designed to keep your personnel healthy and effective at work. Created by our experienced clinical and scientific staff, these resources are built for both prevention and treatment.

ANONYMOUS SELF-ASSESSMENTS

Often, firefighters suspect they are battling a mental health issue but are unsure where to start. Cordico self-assessments are completely confidential and deliver highly specific results and next-step guidance.

WELLNESS TOOLS

Cordico includes videos, articles and guides on more than 60 topics, including:

- Substance Abuse
- Burnout
- Grief and Loss
- Family Support
- Financial Fitness
- Healthy Habits
- Posttraumatic Stress
- Suicide Prevention
- Fitness and Nutrition
- Adult ADHD
- Alcohol Abuse
- Cordico Anger Scale
- Compassion Fatigue
- Posttraumatic Stress
- Resilience
- Cordico Sleep Test
- Social Isolation
- Well-Being

IDENTITY THEFT PROTECTION

NORTON LIFELOCK

Your identity is one of your most important assets. Everyday things like online shopping, banking and even browsing can expose personal information and make you vulnerable to cybercriminals. You can purchase protection through Norton LifeLock to help you and your family live your digital lives safely.

Device Security

Anti-virus software and multi-layered, advanced security helps protect devices against existing and emerging threats, including malware and ransomware

Online Privacy

Norton Secure VPN protects devices and helps keep online activity and browsing history private. Privacy Monitor scans common public people-search websites to help you opt-out. And SafeCam alerts you and blocks attempts to access your webcam.



Identity

We monitor for fraudulent use of personal information, and send alerts when a potential threat is detected.

Home & Family

Take action to monitor your child's online activity with easy-to-use tools to set screen time limits, block unsuitable sites, and monitor search terms and activity history.

ENJOY COMPREHENSIVE IDENTITY THEFT AND DEVICE PROTECTION

BETTER BENEFITS + COMPETITIVE PRICING

Both Plans Include:

- ✓ LifeLock Identity Alert System
- ✓ Prior ID Theft Remediation
- ✓ Privacy Monitor
- ✓ Dark Web Monitoring
- ✓ Social Media Monitoring
- ✓ ID Verification Monitoring
- ✓ \$1M Protection Package
- ✓ Financial Account Activity Alerts
- ✓ Lost Wallet Protection
- ✓ Password Manager
- ✓ Norton Device Security
- ✓ Norton Family Parental Controls
- ✓ PC SafeCam
- ✓ Norton Secure VPN
- ✓ Phone Number Takeover

 LifeLock™ with Norton Benefit Essential
\$7.99 /per employee
\$15.98 /per family
1B Credit Monitoring
1B Credit Application Alerts
Monthly 1B Credit Report + Score
3 EE / 6 FAM Norton Device Protection
10GB Online Backup

 LifeLock™ with Norton Benefit Premier
\$13.49 /per employee
\$26.98 /per family
3B Credit Monitoring
Annual 3B Credit Reports + Scores
Daily 1B Credit Report + Score
Monthly Credit Score Tracking
5 EE / 10 FAM Norton Device Protection
50GB Online Backup
Home Title Monitoring
New Checking & Savings Application Alerts
Bank Account Takeover Alerts

GLOSSARY OF MEDICAL TERMS

INSURANCE TERMS

▶ [Benefit Terms Explained](#)

-  **Coinsurance**—The plan's share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. You pay any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and non-network services.
-  **Copays**—A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care or emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.
-  **Deductible**—The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services, as required under the Affordable Care Act.
-  **Lifetime Benefit Maximum**—All plans are required to have an unlimited lifetime maximum.
-  **Network Provider**—A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.
-  **Out-of-pocket Maximum**—The most you will pay during a set period of time before your health insurance begins to pay 100% of the
-  **Preauthorization**—A process by your health insurer or plan to determine if any service, treatment plan, prescription drug or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval or precertification.
-  **UCR (Usual, Customary and Reasonable)**—The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.
-  **EOI (Evidence of Insurability)**—A process where your insurance carrier determines whether you (or your dependents) are eligible for certain benefits. The EOI form is a comprehensive medical questionnaire that gives your carrier the information they need to make their decision.

MEDICAL TERMS

-  **Prescription Drugs**—Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.
-  **Urgent Care**—Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.
-  **Emergency Room**—Services you receive from a hospital for any serious condition requiring immediate care.
-  **Preventive Services**—All services coded as Preventive must be covered 100% without a deductible, coinsurance or copayments.
-  **Medically Necessary**—Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

IMPORTANT LEGAL NOTICES

MEDICARE PART D CREDITABLE COVERAGE

Important Notice from Northwest Fire District About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Northwest Fire District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Northwest Fire District has determined that the prescription drug coverage offered by the Choice Plus HSA health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Northwest Fire District coverage may be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop the Northwest Fire District medical plan, **be aware that you and your dependents may not be able to get this coverage back.**

IMPORTANT LEGAL NOTICES

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Northwest Fire District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Northwest Fire District changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	September 1, 2022
Name of Entity/Sender:	Northwest Fire District, Inc.
Contact--Position/Office:	Nichole Robertson, Human Resource Services Analyst
Address:	13535 N. Marana Main Street Marana, AZ 85653
Phone Number:	(520) 887-1010 ext.2932

IMPORTANT LEGAL NOTICES

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility.

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhcpp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	COLORADO-Health First Colorado (Colorado's Medicaid Program) & ChildHealth Plan Plus (CHP+)
The AK Health Insurance Premium Payment Program Website: http://myakhcpp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	FLORIDA-Medicaid
Website: http://myarhcpp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268

IMPORTANT LEGAL NOTICES

GEORGIA-Medicaid	MASSACHUSETTS-Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA-Medicaid	MINNESOTA-Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA-Medicaid and CHIP (Hawki)	MISSOURI-Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS-Medicaid	MONTANA-Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov
KENTUCKY-Medicaid	NEBRASKA-Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA-Medicaid	NEVADA-Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/la hipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE-Medicaid	NEW HAMPSHIRE-Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

IMPORTANT LEGAL NOTICES

NEW JERSEY-Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	SOUTH DAKOTA-Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK-Medicaid Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	TEXAS-Medicaid Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA-Medicaid Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	UTAH-Medicaid and CHIP Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA-Medicaid Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	VERMONT-Medicaid Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA-Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	VIRGINIA-Medicaid and CHIP Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON-Medicaid Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	WASHINGTON-Medicaid Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA-Medicaid Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	WEST VIRGINIA-Medicaid and CHIP Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855 MyWVHIPP (1-855-699-8447)
RHODE ISLAND-Medicaid and CHIP Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)	WISCONSIN-Medicaid and CHIP Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA-Medicaid Website: https://www.scdhhs.gov Phone: 1-888-549-0820	WYOMING-Medicaid Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

IMPORTANT LEGAL NOTICES

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

This notice is a summary. For a full description of all of Northwest Fire District's benefit plans, please refer to the Summary Plan Descriptions.

IMPORTANT LEGAL NOTICES

INITIAL COBRA NOTICE *[FOR NEW HIRES OR NEW BENEFITS ELIGIBLE ONLY]*

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

IMPORTANT LEGAL NOTICES

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Northwest Fire District, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

Nichole Robertson
Human Resources Services Analyst
(520) 887-1010 ext.2932
NRobertson@nwfdaz.gov

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

IMPORTANT LEGAL NOTICES

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must provide this to:

Nichole Robertson
Human Resources Services Analyst
(520) 887-1010 ext.2932
NRobertson@nwfdaz.gov

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes.

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

IMPORTANT LEGAL NOTICES

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Nichole Robertson
Human Resources Services Analyst
(520) 887-1010 ext.2932
NRobertson@nwfdaz.gov

This notice is a summary. For a full description of all of Northwest Fire District's benefit plans, please refer to the Summary Plan Descriptions.

IMPORTANT LEGAL NOTICES

MARKETPLACE COVERAGE OPTIONS [FOR NEW HIRES ONLY]

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your summary plan description or contact Northwest Fire District's HR department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

IMPORTANT LEGAL NOTICES

MARKETPLACE COVERAGE OPTIONS CONTINUED [FOR NEW HIRES ONLY]

PART B: Information About Health Coverage Offered By Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

Employer Name: Northwest Fire District	Employer Identification Number (EIN): 86-0472471
Employer Address: 13535 N. Marana Main Street Marana, AZ 85653	Employer Phone Number: (520) 887-1010
Who can we contact about employee health coverage at this job? Nichole Robertson	Phone Number: (520) 887-1010 ext. 2932 Email Address: hr@nwfdaz.org

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
All employees. Eligible employees are:
 - ☐ Full time employees, working a minimum 30 hours per week on a regular basis. Employees will be effective the 1st day of the month, following 30 days of employment.
 - ☐ Some employees. Eligible employees are:
- With respect to dependents:
 - ☐ We do offer coverage. Eligible dependents are:
 - ☐ We do not offer coverage.
- ☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Above is the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

This notice is a summary. For a full description of all of Northwest Fire District's benefit plans, please refer to the Summary Plan Descriptions.

IMPORTANT LEGAL NOTICES

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you have had, or are going to have, a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles apply: \$1,500 / \$3,000. If you would like more information on WHCRA benefits, call your Plan Administrator (520) 887-1010 EXT. 2932.

IMPORTANT INFORMATION REGARDING 1095 FORMS

As an employer with 50 or more full-time employees, we are required to provide 1095-C forms to each employee who was employed as a full-time employee for at least one month during the calendar year, without regard to whether he/she was covered by our group health plan. These employees should expect to receive their Form 1095-C in early March 2023. We are also required to send a copy of your 1095-C form to the IRS.

The information reported on Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by you and the IRS to determine eligibility for the premium tax credit.

SPECIAL ENROLLMENT NOTICE

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans.

If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. You must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll any new dependent within 30 days of the event.

If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

If you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

To request special enrollment or obtain more information, contact Human Resources.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA OR "NEWBORNS' ACT") NOTICE

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging

the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

IMPORTANT LEGAL NOTICES

Northwest Fire District reserves the right to change, amend, or terminate any benefits plan at any time for any reason. Participation in a benefit plan is not a promise or guarantee of future employment. Receipt of benefits documents does not constitute eligibility.

This Benefits Guide, combined with these legal notices, provides an overview of the benefits available to you and your family. In the event of a discrepancy between the information presented in the Benefits Guide and official plan documents, the official plan documents will govern.

STATEMENT OF MATERIAL MODIFICATIONS (ERISA PLANS)

This Benefits Guide constitutes a summary of modifications to the employer's group health plan. It is meant to supplement and/or replace certain information in the existing plan descriptions. Please share these materials with your covered family members.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although Northwest Fire District may use aggregate information it collects to design a program based on identified health risks in the workplace, the health plan will never disclose any of your personal health information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are health professionals in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Nichole Robertson at (520) 887-1010 ext.2932.

MEDICAL LOSS RATIO (MLR) RULE NOTICE

The Affordable Care Act requires health insurers in the individual and small group markets to spend at least 80 percent of the premiums they receive on health care services and activities to improve health care quality (in the large group market of 51+ employees, this amount is 85 percent). This is referred to as the Medical Loss Ratio (MLR) rule or the 80/20 rule. If a health insurer does not spend at least 80 (85 for large groups) percent of the premiums it receives on health care services and activities to improve health care quality, the insurer must rebate the difference.

IMPORTANT LEGAL NOTICES

WELLNESS PROGRAM NOTICE

EEOC NOTICE

Northwest Fire District Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. You are not required to complete the HRA or to participate in the blood test or other medical examinations. Although you are not required to participate in the wellness program, only employees who do so will receive the incentive. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Nichole Robertson at (520) 887-1010 ext.2932 or NRobertson@nwfdaz.gov. The results obtained from the wellness program will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

NOTICE OF HIPAA PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice is intended to inform you of the privacy practices followed by the Northwest Fire District, Inc. Health Plan and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on 12/08/2021.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the plan participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. Northwest Fire District, Inc. requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

IMPORTANT LEGAL NOTICES

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or required by law. We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to Your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of Northwest Fire District, Inc. for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

CONTACTS

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend.

Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the protected health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities. We are required by law to protect the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with this notice about our privacy practices, and follow the information practices that are described in this notice.

We may change our policies at any time. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time.

For more information about our privacy practices, contact the person listed below. If you have any questions or complaints, please contact:

Nichole Robertson
Human Resources Services Analyst
(520) 887-1010 ext 2932
NRobertson@nwfdaz.gov

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

IMPORTANT LEGAL NOTICES

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

“Out-of-network” means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

As of February 2021, the following 18 states had enacted comprehensive Balance Billing Protections: California, Colorado, Connecticut, Florida, Georgia, Illinois, Maine, Maryland, Michigan, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oregon Texas, Virginia, Washington.

As of February 2021, the following 15 states had enacted limited Balance-Billing Protections: Arizona, Delaware, Indiana, Iowa, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, Nevada, North Carolina, Pennsylvania, Rhode Island, Vermont, West Virginia.

Generally, those state passed protections apply to fully insured medical plans governed by the specific state and not self-funded medical plans. Check the state insurance commissioner website for details on specific state laws. If your state is not listed, check your state commissioner's website as states may adopt a surprising billing mandate at any time.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

IMPORTANT LEGAL NOTICES

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - ⇒ Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
 - ⇒ Cover emergency services by out-of-network providers.
 - ⇒ Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - ⇒ Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, you may contact the US Dept. of Health & Human Services at 1-877-696-6775 or your State Insurance Commissioner.

CONTACTS

	Vendor Name	Group Number	Contact Info
Company Contact	Northwest Fire District Human Resource Services	N/A	hr@nwfdaz.gov
Employee Assistance Program	SupportLinc	02779	888-881-5462 www.supportlinc.com
Medical	United Healthcare	0925889	Choice Plus HSA 866-734-7679 www.uhc.com
Dental	United Healthcare	0925889	800-244-6224 www.uhc.com
Vision	VSP	30085807	800-877-7195 www.vsp.com
Basic, Voluntary Life and AD&D	The Standard	164947	800-368-2859 www.standard.com
Disability	The Standard	164947	800-368-2859 www.standard.com
Business Travel Accident (BTA)	The Hartford	59-GTA-101473	866-311-1559 www.thehartford.com
Accident & Critical Illness	Transamerica	G000023628	888-622-5558 www.nbcbenefits.com
HSA	WEX	41524	800-492-0669 www.wexinc.com
HRA	WEX	41524	800-492-0669 www.wexinc.com
Flexible Spending Account	WEX	41524	800-492-0669 www.wexinc.com
Retirement Plans	Nationwide	ASRS 457	520-262-0348 www.nrsforu.com



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CBZ. All rights reserved.

The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the plans as described in this material and official plan documents, the language of the documents shall govern.



SECTION 3

CLAIMS REPORTING & FINANCIAL DOCUMENTS SAMPLES



Sample Client Medical and Pharmacy Experience

Plan Year: *April 2022 – March 2023*

Month End: *November 2022*

Presented by your CBIZ Team

Elizabeth Dempsey and Oscar Diaz



our **business**
is growing **yours.**



Sample Client
Medical Plan Costs - All Plans
Plan Year April 2022 to March 2023 (as of November 2022)

Monthly Costs (via United HealthCare)										Loss Ratio		PEPM Costs			
Paid Month	Subscribers	Expected Claims Liability	Maximum Claims Liability	Paid Medical Claims	Paid Rx Claims	Stop Loss Recovery *	Total Paid Claims	Admin Fees	Total Paid Claims & Fees	% Actual Claims vs. Expected Claims Liability	% Actual Claims vs. Maximum Claims Liability	Total Paid Medical Claims PEPM	Total Paid Rx Claims PEPM	Total Paid Claims PEPM	Total Paid Claims & Fees PEPM
	A	B	C	D	E	F	G = (D+E+F)	H	I = (G+H)	J = (G/B)	K = (G/C)	L = (D/A)	M = (E/A)	N = (G/A)	O = (I/A)
Apr-22	120	\$66,767	\$62,280	\$45,647	\$14,376	\$0	\$60,023	\$22,284	\$82,307	89.9%	96.4%	\$380.39	\$119.80	\$500.19	\$685.89
May-22	121	\$68,019	\$62,799	\$38,662	\$11,068	\$0	\$49,730	\$22,470	\$72,200	73.1%	79.2%	\$319.52	\$91.47	\$410.99	\$596.69
Jun-22	123	\$68,628	\$63,837	\$26,798	\$23,395	\$0	\$50,193	\$22,841	\$73,034	73.1%	78.6%	\$217.87	\$190.20	\$408.07	\$593.77
Jul-22	121	\$67,387	\$62,799	\$44,860	\$11,378	\$0	\$56,238	\$22,470	\$78,708	83.5%	89.6%	\$370.75	\$94.04	\$464.78	\$650.48
Aug-22	121	\$67,295	\$62,799	\$27,927	\$17,830	\$0	\$45,757	\$22,470	\$68,227	68.0%	72.9%	\$230.80	\$147.36	\$378.16	\$563.86
Sep-22	121	\$68,078	\$62,799	\$18,452	\$16,507	(\$7,400)	\$27,558	\$22,470	\$50,028	40.5%	43.9%	\$152.49	\$136.42	\$227.75	\$413.45
Oct-22	123	\$69,529	\$63,837	\$53,161	\$12,449	(\$38,625)	\$26,986	\$22,841	\$49,827	38.8%	42.3%	\$432.21	\$101.21	\$219.40	\$405.10
Nov-22	124	\$69,788	\$64,356	\$33,794	\$23,820	(\$21,249)	\$36,365	\$23,027	\$59,392	52.1%	56.5%	\$272.53	\$192.10	\$293.27	\$478.97
Dec-22															
Jan-23															
Feb-23															
Mar-23															
Total	974	\$545,490	\$505,506	\$289,301	\$130,823	(\$67,274)	\$352,851	\$180,872	\$533,722	64.7%	69.8%	\$297.02	\$134.32	\$431.34	\$547.97

* includes received and outstanding amounts

Admin Fees	All Tiers
Administration	\$56.50
Specific Stoploss (\$125,000)	\$94.50
Aggregate Stoploss (120% - 12/12 with TLO)	\$34.70
Total Fixed Expenses	\$185.70

Contractual Maximum Liability - Sun Life	\$519.00



Sample Client

Medical Plan Costs - Core Plan

Plan Year April 2022 to March 2023 (as of November 2022)

Monthly Costs (via UnitedHealthcare)										Loss Ratio		PEPM Costs			
Paid Month	Subscribers	Expected Claims Liability	Maximum Claims Liability	Paid Medical Claims	Paid Rx Claims	Stop Loss Recovery *	Total Paid Claims	Admin Fees	Total Paid Claims & Fees	% Actual Claims vs. Expected Claims Liability	% Actual Claims vs. Maximum Claims Liability	Total Paid Medical Claims PEPM	Total Paid Rx Claims PEPM	Total Paid Claims PEPM	Total Paid Claims & Fees PEPM
	A	B	C	D	E	F	G=(D+E+F)	H	I = (G+H)	J = (G/B)	K = (G/C)	L = (D/A)	M = (E/A)	N = (G/A)	O = (I/A)
Apr-22	88	\$39,980	\$47,976	\$9,714	\$3,502	\$0	\$13,216	\$16,342	\$29,558	33.1%	27.5%	\$110.38	\$39.80	\$150.18	\$335.88
May-22	87	\$39,722	\$47,666	\$5,316	\$3,770	\$0	\$9,086	\$16,156	\$25,242	22.9%	19.1%	\$61.11	\$43.33	\$104.43	\$290.13
Jun-22	89	\$39,456	\$47,347	\$6,820	\$3,132	\$0	\$9,952	\$16,527	\$26,479	25.2%	21.0%	\$76.63	\$35.19	\$111.82	\$297.52
Jul-22	86	\$37,897	\$45,476	\$3,152	\$1,276	\$0	\$4,428	\$15,970	\$20,398	11.7%	9.7%	\$36.65	\$14.84	\$51.49	\$237.19
Aug-22	86	\$38,680	\$46,416	\$5,694	\$2,371	\$0	\$8,065	\$15,970	\$24,035	20.9%	17.4%	\$66.21	\$27.56	\$93.78	\$279.48
Sep-22	86	\$39,463	\$47,356	\$5,655	\$3,545	\$0	\$9,200	\$15,970	\$25,170	23.3%	19.4%	\$65.76	\$41.22	\$106.97	\$292.67
Oct-22	87	\$39,722	\$47,666	\$13,254	\$2,335	\$0	\$15,588	\$16,156	\$31,744	39.2%	32.7%	\$152.34	\$26.84	\$179.18	\$364.88
Nov-22	88	\$39,980	\$47,976	\$5,200	\$2,339	\$0	\$7,539	\$16,342	\$23,881	18.9%	15.7%	\$59.09	\$26.58	\$85.67	\$271.37
Dec-22															
Jan-23															
Feb-23															
Mar-23															
Total	697	\$314,899	\$377,880	\$54,805	\$22,269	\$0	\$77,074	\$129,433	\$206,507	24.5%	20.4%	\$78.63	\$31.95	\$110.58	\$296.28

* includes received and outstanding amounts

Admin Fees	
Administration	\$56.50
Specific Stoploss (\$125,000)	\$94.50
Aggregate Stoploss (120% - 12/12 with TLO)	\$34.70
Total Fixed Expenses	\$185.70

	EE	EE & Fam
Expected Claims Liability (PEPM)	\$258.55	\$1,041.63
Maximum Claims Liability (PEPM)	\$310.26	\$1,249.96

Month	Enrollment by Tier		Total	Monthly Admin Fee
	Employee Only	Employee + Family		
April	66	22	88	\$16,342
May	65	22	87	\$16,156
June	68	21	89	\$16,527
July	66	20	86	\$15,970
August	65	21	86	\$15,970
September	64	22	86	\$15,970
October	65	22	87	\$16,156
November	66	22	88	\$16,342
December				\$0
January				\$0
February				\$0
March				\$0
Total	525	172	697	\$129,433

Sample Client
Medical Plan Costs - Buy-Up Plan
Plan Year April 2022 to March 2023 (as of November 2022)

Monthly Costs (via UnitedHealthcare)										Loss Ratio		PEPM Costs			
Paid Month	Subscribers	Expected Claims Liability	Maximum Claims Liability	Paid Medical Claims	Paid Rx Claims	Stop Loss Recovery *	Total Paid Claims	Admin Fees	Total Paid Claims & Fees	% Actual Claims vs. Expected Claims Liability	% Actual Claims vs. Maximum Claims Liability	Total Paid Medical Claims PEPM	Total Paid Rx Claims PEPM	Total Paid Claims PEPM	Total Paid Claims & Fees PEPM
	A	B	C	D	E	F	G=(D+E+F)	H	I = (G+H)	J = (G/B)	K = (G/C)	L = (D/A)	M = (E/A)	N = (G/A)	O = (I/A)
Apr-22	32	\$26,787	\$32,144	\$35,933	\$10,874	\$0	\$46,807	\$5,942	\$52,749	174.7%	145.6%	\$1,122.92	\$339.80	\$1,462.72	\$1,648.42
May-22	34	\$28,297	\$33,957	\$33,346	\$7,299	\$0	\$40,644	\$6,314	\$46,958	143.6%	119.7%	\$980.75	\$214.67	\$1,195.42	\$1,381.12
Jun-22	34	\$29,172	\$35,006	\$19,978	\$20,263	\$0	\$40,241	\$6,314	\$46,555	137.9%	115.0%	\$587.59	\$595.97	\$1,183.56	\$1,369.26
Jul-22	35	\$29,490	\$35,388	\$41,709	\$10,102	\$0	\$51,811	\$6,500	\$58,310	175.7%	146.4%	\$1,191.67	\$288.63	\$1,480.30	\$1,666.00
Aug-22	35	\$28,615	\$34,338	\$22,233	\$15,459	\$0	\$37,692	\$6,500	\$44,192	131.7%	109.8%	\$635.22	\$441.70	\$1,076.92	\$1,262.62
Sep-22	35	\$28,615	\$34,338	\$12,796	\$12,962	(\$7,400)	\$18,358	\$6,500	\$24,858	64.2%	53.5%	\$365.61	\$370.35	\$524.52	\$710.22
Oct-22	36	\$29,807	\$35,769	\$39,907	\$10,115	(\$38,625)	\$11,397	\$6,685	\$18,083	38.2%	31.9%	\$1,108.54	\$280.96	\$316.59	\$502.29
Nov-22	36	\$29,807	\$35,769	\$28,594	\$21,481	(\$21,249)	\$28,826	\$6,685	\$35,512	96.7%	80.6%	\$794.29	\$596.69	\$800.73	\$986.43
Dec-22															
Jan-23															
Feb-23															
Mar-23															
Total	277	\$230,590	\$276,708	\$234,496	\$108,554	(\$67,274)	\$275,777	\$51,439	\$327,216	119.6%	99.7%	\$846.56	\$391.89	\$1,238.45	\$1,181.28

* includes received and outstanding amounts

Admin Fees	
Administration	\$56.50
Specific Stoploss (\$125,000)	\$94.50
Aggregate Stoploss (120% - 12/12 with TLO)	\$34.70
Total Fixed Expenses	\$185.70

	EE	EE & Fam
Expected Claims Liability (PEPM)	\$317.70	\$1,192.47
Maximum Claims Liability (PEPM)	\$381.24	\$1,430.96

Month	Enrollment by Tier		Total	Monthly Admin Fee
	Employee Only	Employee + Family		
April	13	19	32	\$5,942
May	14	20	34	\$6,314
June	13	21	34	\$6,314
July	14	21	35	\$6,500
August	15	20	35	\$6,500
September	15	20	35	\$6,500
October	15	21	36	\$6,685
November	15	21	36	\$6,685
December				\$0
January				\$0
February				\$0
March				\$0
Total	114	163	277	51,439

Sample Client
Medical Plan Costs - All Plans
Plan Year April 2021 to March 2022 (as of March 2022)

Monthly Costs (via United HealthCare)										Loss Ratio		PEPM Costs			
Paid Month	Subscribers	Expected Claims Liability	Maximum Claims Liability	Paid Medical Claims	Paid Rx Claims	Stop Loss Recovery *	Total Paid Claims	Admin Fees	Total Paid Claims & Fees	% Actual Claims vs. Expected Claims Liability	% Actual Claims vs. Maximum Claims Liability	Total Paid Medical Claims PEPM	Total Paid Rx Claims PEPM	Total Paid Claims PEPM	Total Paid Claims & Fees PEPM
	A	B	C	D	E	F	G = (D+E+F)	H	I = (G+H)	J = (G/B)	K = (G/C)	L = (D/A)	M = (E/A)	N = (G/A)	O = (I/A)
Apr-21	130	\$43,368	\$55,770	\$45,785	\$6,393	\$0	\$52,178	\$22,302	\$74,480	120.3%	93.6%	\$352.19	\$49.18	\$401.37	\$572.92
May-21	130	\$43,846	\$55,770	\$39,829	\$8,558	\$0	\$48,387	\$22,302	\$70,689	110.4%	86.8%	\$306.38	\$65.83	\$372.21	\$543.76
Jun-21	126	\$42,148	\$54,054	\$55,036	\$24,282	\$0	\$79,318	\$21,615	\$100,934	188.2%	146.7%	\$436.80	\$192.71	\$629.51	\$801.06
Jul-21	123	\$40,715	\$52,767	\$39,191	\$6,258	\$0	\$45,450	\$21,101	\$66,551	111.6%	86.1%	\$318.63	\$50.88	\$369.51	\$541.06
Aug-21	119	\$39,018	\$51,051	\$42,841	\$8,958	\$0	\$51,799	\$20,414	\$72,213	132.8%	101.5%	\$360.01	\$75.27	\$435.28	\$606.83
Sep-21	119	\$39,495	\$51,051	\$30,761	\$6,653	\$0	\$37,414	\$20,414	\$57,828	94.7%	73.3%	\$258.50	\$55.90	\$314.40	\$485.95
Oct-21	121	\$39,814	\$51,909	\$38,521	\$6,126	\$0	\$44,648	\$20,758	\$65,405	112.1%	86.0%	\$318.36	\$50.63	\$368.99	\$540.54
Nov-21	122	\$40,451	\$52,338	\$43,257	\$10,248	(\$15,532)	\$37,972	\$20,929	\$58,901	93.9%	72.6%	\$354.57	\$84.00	\$311.25	\$482.80
Dec-21	121	\$41,272	\$51,909	\$56,001	\$18,225	(\$16,972)	\$57,255	\$20,758	\$78,012	138.7%	110.3%	\$462.82	\$150.62	\$473.18	\$644.73
Jan-22	123	\$41,591	\$52,767	\$47,696	\$7,947	(\$25,713)	\$29,930	\$21,101	\$51,031	72.0%	56.7%	\$387.77	\$64.61	\$243.33	\$414.88
Feb-22	121	\$41,272	\$51,909	\$15,532	\$10,331	(\$5,901)	\$19,961	\$20,758	\$40,719	48.4%	38.5%	\$128.36	\$85.38	\$164.97	\$336.52
Mar-22	119	\$40,475	\$51,051	\$28,446	\$14,466	(\$19,920)	\$22,992	\$20,414	\$43,406	56.8%	45.0%	\$239.04	\$121.56	\$193.21	\$364.76
Total	1,474	\$493,464	\$632,346	\$482,897	\$128,444	(\$84,038)	\$527,304	\$252,865	\$780,168	106.9%	83.4%	\$327.61	\$87.14	\$414.75	\$529.29

* includes received and outstanding amounts

Admin Fees	All Tiers
Administration	\$59.95
Specific Stoploss (\$125,000)	\$77.60
Aggregate Stoploss (120% - 12/12 with TLO)	\$34.00
Total Fixed Expenses	\$171.55

Contractual Maximum Liability - Sun Life	\$429.00



Sample Client

Annual Cost Comparison

Plan Year April 2022 to March 2023 (as of November 2022)

2021/2022 PY vs. 2022/2023 PY

Cost Categories	2021/2022 Annual Cost	PEPM Costs	2022/2023 Estimated Annual Cost	PEPM Costs
Medical Claims	\$482,897	\$327.61	\$433,952	\$297.02
Rx Claims	\$128,444	\$87.14	\$196,235	\$134.32
Total Medical & Rx Claims	\$611,341	\$414.75	\$630,187	\$431.34
Stop Loss Recoveries***	(\$84,038)	(\$57.01)	(\$67,274)	(\$46.05)
Admin Fees	\$252,865	\$171.55	\$271,308	\$185.70
Total Costs	\$780,168	\$529.29	\$834,220	\$570.99

% Cost Change	\$ Cost Change	% PEPM Change	\$ PEPM Change
(10.1%)	(\$48,945)	(9.3%)	(\$30.59)
52.8%	\$67,790	54.1%	\$47.18
3.1%	\$18,845	4.0%	\$16.59
	\$16,764		
7.3%	\$18,443	8.2%	\$14.15
6.9%	\$54,052	7.9%	\$41.71

PEPM Total Cost History		Increase/Decrease
2011-2012	\$416.10	
2012-2013	\$636.41	52.9%
2013-2014	\$642.57	1.0%
2014-2015	\$546.54	(14.9%)
2015-2016	\$524.05	(4.1%)
2016-2017	\$691.05	31.9%
2017-2018	\$472.95	(31.6%)
2018-2019	\$438.10	(7.4%)
2019-2020	\$453.76	3.6%
2020-2021	\$452.42	(0.3%)
2021-2022	\$529.29	17.0%
2022-2023	\$570.99	7.9%

	Annual
Subscribers	1,474

Annualized
1,461

% Subscriber Change	# Subscriber Change
(0.9%)	(13)

***Stop Loss & Aggregate Stop Loss Recoveries are not annualized.

2020/2021 PY vs. 2021/2022 PY

Cost Categories	2020/2021 Annual Cost	PEPM Costs	2021/2022 Annual Cost	PEPM Costs
Medical Claims	\$383,765	\$240.76	\$482,897	\$327.61
Rx Claims	\$179,423	\$112.56	\$128,444	\$87.14
Total Medical & Rx Claims	\$563,188	\$353.32	\$611,341	\$414.75
Stop Loss Recoveries***	(\$107,568)	(\$67.48)	(\$84,038)	(\$57.01)
Admin Fees	\$265,544	\$166.59	\$252,865	\$171.55
Total Costs	\$721,164	\$452.42	\$780,168	\$529.29

% Cost Change	\$ Cost Change	% PEPM Change	\$ PEPM Change
25.8%	\$99,132	36.1%	\$86.85
(28.4%)	(\$50,978)	(22.6%)	(\$25.42)
8.6%	\$48,153	17.4%	\$61.43
	\$23,530		
(4.8%)	(\$12,680)	3.0%	\$4.96
8.2%	\$59,004	17.0%	\$76.86

	Annual
Subscribers	1,594

Annualized
1,474

% Subscriber Change	# Subscriber Change
(7.5%)	(120)

***Stop Loss & Aggregate Stop Loss Recoveries are not annualized.



Sample Client
UnitedHealthCare - Large Claimant Report over \$25K
Plan Year: April 2022 to March 2023 (as of November 2022)

Claimant	Unique ID	Prior Year Large Claimant (Y/N)	Enrollment Status	Gender	Relationship	Plan	Diagnosis	Previous Month's YTD Paid Claims	Current Month's YTD Paid Claims	Change from Prior Month's Paid Claims	% of Individual \$125K Spec.	Stop Loss Recovery *	Net Paid after Stop Loss Reimbursements
1	C002	Y	Active	M	Subscriber	Buy Up	Unspecified optic neuritis	\$171,025	\$192,274	\$21,249	100%	(\$67,274)	\$125,000
Total								\$171,025	\$192,274	\$21,249		(\$67,274)	\$125,000
Percentage of Large Claims vs. Medical & Rx Claims									45.8%				



Sample Client

Medical, Pharmacy, Dental and Vision Funding Projection For a July 1, 2023 Effective Date

Completed March, 2023, v2

Renew with No Plan Changes; Preliminary ISL renewal

Presented by:
CBIZ Benefits & Insurance Services, Inc.
1765 E. Skyline Drive
Tucson, Arizona 85718
Telephone: (520) 327-6421



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Section 3

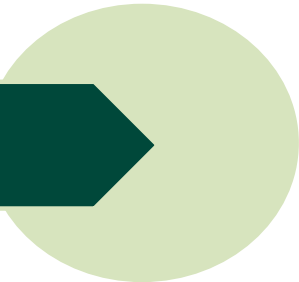
Fixed Cost Assumptions

Section 4

Claims and Enrollment Data



Section 1: Funding Summary





Sample Client

Medical, Pharmacy, Dental and Vision Funding Projection For a July 1, 2023 Effective Date
— Summary —

1. Current Enrollment (January 2023)

	<u>PPO 500</u>
Employee Only	138
Employee + Family	<u>165</u>
Total	303

2. 2022/2023 Sample Client Funding Rates

	<u>PPO 500</u>
Employee Only	\$481.70
Employee + Family	<u>\$1,232.49</u>
PEPM:	\$890.55
Monthly:	\$269,835
Annual:	\$3,238,025

3. Forecasted 2023/2024 Rate Action

Expected	-4.53%	
Very High End	36.78%	<i>(Carriers Max Medical & Rx Liability plus Dental and Vision)</i>
Low End	-9.53%	
Used	0.00%	

4. Forecasted 2023/2024 Funding Rates

	<u>PPO 500</u>
Employee Only	\$481.70
Employee + Family	<u>\$1,232.49</u>
PEPM:	\$890.55
Monthly:	\$269,835
Annual:	\$3,238,025

Sample Client

Medical, Pharmacy, Dental and Vision Funding Projection For a July 1, 2023 Effective Date — Summary —

5. Fixed Costs as a % of Expected Funding Rates

Administration:	8.44%
Stop Loss:	12.71%
PCORI:	<u>0.07%</u>
Total:	21.22%

Under Traditional Program:

Administration & Stop Loss Range is between 15.9% to 24.9%

6. Assumptions

Med & Rx Experience Period: Used 24 months of paid claims: Year 1 (Current) from 2/1/22 - 1/31/23 and Year 2 (Prior) From 2/1/21 - 1/31/22. Blended 80% Current Year and 20% Prior Year for Medical and Pharmacy; blended 80% Current Year and 20% Prior Year for Vision; and blended 80% Current Year and 20% Prior Year for Dental.

Plan Change: 2022/2023: No plan changes; 2021/2022: No plan changes; 2020/2021: No plan changes; 2019/2020: No plan changes.

Annual Trend: Medical = 7.4% ; Rx = 9.8%; Dental= 4.0%; Vision= 1.5%. For Year 1: 19 Months of Trend and Year 2: 31 Months of Trend. For a slight contribution to reserves, used a 2 month lag, e.g., Incurred Claims from December through November equal paid claims from February through January.

Claim Margin: 2% Medical & Rx; 1% Dental & Vision

COVID Impact Load: 0% Medical & Vision; 0% Dental

Fixed Costs:

	Fixed Costs			
	2022/2023	Estimated 2023/2024	% Change	Estimated Annual
Subscribers	303	303		
Medical Administration Fee ³	\$20.15	\$20.15	0.0%	\$73,265
Network Access Fee ³	\$21.25	\$21.25	0.0%	\$77,265
Mexico Medical Access Fee - IMS	\$3.00	\$3.00	0.0%	\$10,908
Vision Admin Fee	\$0.80	\$0.80	0.0%	\$2,909
Medicare Reporting	\$1.00	\$1.00	0.0%	\$3,636
Acct/BankRec/Financials	\$3.20	\$3.20	0.0%	\$11,635
Utilization Review	\$2.55	\$2.55	0.0%	\$9,272
No Surprise Act	\$0.50	\$1.00	100.0%	\$3,636
Wellness Administration	\$6.19	\$6.19	0.0%	\$22,500
Individual Stop Loss ^{1,2}	\$88.16	\$103.16	17.0%	\$375,093
Aggregate Stop Loss	\$4.57	\$4.89	7.0%	\$17,780
Consulting Fee	<u>\$12.65</u>	<u>\$12.65</u>	0.0%	<u>\$46,000</u>
Total Fixed Costs	\$164.02	\$179.84	9.6%	\$653,899
PCORI Fee	<u>\$0.59</u>	<u>\$0.61</u>	3.39%	<u>\$2,218</u>
Total Fixed Costs and ACA Fees	\$164.61	\$180.45	9.6%	\$656,117

¹ \$125,000 ISL deductible with \$0 aggregating deductible, 125% aggregate corridor, 48/12 contract

² Estimated increase of 17% on ISL and 7% on ASL.

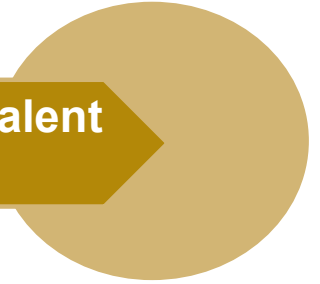
³ Medical & Network Admin Fee received 0% increase.

7. Internal Financial Validation Test — Projected Claims Compared to Historical Claims * Note: includes 19 months of trend *

	PEPM	% Increase	Monthly Average	% Increase
Average Paid Claims Most Recent 12 Months (Not adjusted for large claims -- see pg. 15)	\$590.93		\$175,457	
Projected 2023/2024 Claims (See pg. 11)	\$670.35	13.4%	\$203,115	15.8%
Average Paid Claims Most Recent 12 Months (Adjusted for large claims -- see pg. 15)	\$590.93			
Projected 2023/2024 Claims	\$670.35	13.4%		



Section 2: Projections to Develop Premium Equivalent Rates



Medical, Pharmacy, Dental and Vision Funding Projection For a July 1, 2023 Effective Date
— Medical Claims Projection —

-
- 31

- \$529.31

Sample Client

Medical, Pharmacy, Dental and Vision Funding Projection For a July 1, 2023 Effective Date — Pharmacy Claims Projection —

1. Objective Develop funding rates which cover all pharmacy paid claims and associated administrative expenses.

2. Assumptions

- a. Rx Trend: 9.8% (Segal 2023)
- b. Enrollment: Lagged 2 months
- c. Experience: Per experience reports provided by Summit
- d. Pooled Claims: None — Removed from Medical
- e. Benefit Changes: See Medical; Year 1 = 1.000, Year 2 = 1.000
- f. Rx Discount %: 43.7%
- g. Chronic Condition: 0.0%
- h. Fluctuation Margin: 2.0%
- i. Current Enrollment: 303 (January 2023)

Months of Trend:

Year 1

19

Year 2

31

3. Algorithm

Paid Period:
Incurred Period:
Midpoint:
Average Enrollment:

Year 1

2/1/22 - 1/31/23
12/1/21 - 11/30/22
6/1/2022
297

Year 2

2/1/21 - 1/31/22
12/1/20 - 11/30/21
6/1/2021
284

- a. Pharmacy Paid Claims \$230,682 \$401,073
- b. Pooled Claims \$0 \$0
- c. Adjusted Paid Claims (a less b) \$230,682 \$401,073
- d. Change in Reserve (Lagged Claims) 1.000 1.000
- e. Network Change 1.000 1.000
- f. Adjusted Paid Claims (c x d x e) \$230,682 \$401,073
- g. Trend Adjustment Factor 1.160 1.273
- h. Trended Adjusted Paid Claims (f x g) \$267,486 \$510,637
- i. Add in Individuals Claims to Pooled Level \$0 \$0
- j. Plan Change Adjustment Factor 1.000 1.000
- k. Enrollment Change Adjustment Factor 1.020 1.067
- l. Chronic Health Conditions / Rx Mgmt / Rx Rebate Adjustment Factor 0.782 0.563
- m. Projected Experience Paid Claims [(h + i) x j x k + l] \$213,323 \$306,632
- n. Claim Fluctuation Margin 1.02 1.02
- o. Projected Experience Paid Claims with Margin (m x n) \$217,589 \$312,765
- p. Claim Rate

PEPM:
Monthly:
Annual:

\$59.84
\$18,132
\$217,589.41

\$86.02
\$26,064
\$312,764.98

Credibility:

80%

20%

PEPM Blended Rate:

\$65.08



Sample Client
Medical, Pharmacy, Dental and Vision Funding Projection For a July 1, 2023 Effective Date
— Dental Claims Projection —

1. Objective Develop funding rates which cover all dental paid claims and associated administrative expenses.

2. Assumptions

			Year 1	Year 2
a. Dental Trend:	4.00%	(Segal 2023)	Months of Trend: 19	31
b. Enrollment:	Lagged 2 months			
c. Experience:	Per experience reports provided by Summit			
d. Pooled Claims:	N/A			
e. Benefit Changes:	2022/2023: No plan changes	2021/2022: No plan changes		
	2020/2021: No plan changes	2019/2020: No plan changes		
f. Other Load/Decrement:	0.0%	COVID -19 Impact Load due to pent-up demand		
g. Fluctuation Margin:	1.0%			
h. Current Enrollment:	303	(January 2023)		

3. Algorithm

		Year 1	Year 2
	Paid Period:	2/1/22 - 1/31/23	2/1/21 - 1/31/22
	Incurred Period:	12/1/21 - 11/30/22	12/1/20 - 11/30/21
	Midpoint:	6/1/2022	6/1/2021
	Average Enrollment:	297	284
a. Dental Paid Claims		\$230,627	\$217,785
b. Change in Reserve (Lagged Claims)		1.000	1.000
c. Network Change		1.000	1.000
d. Adjusted Paid Claims (a x b x c)		\$230,627	\$217,785
e. Trend Adjustment Factor		1.064	1.107
f. Trended Adjusted Paid Claims (d x e)		\$245,403	\$241,008
g. Plan Change Adjustment Factor		1.000	1.000
h. Enrollment Change Adjustment Factor		1.020	1.067
i. COVID-19 Impact Load		1.00	1.00
j. Projected Experience Paid Claims (f x g x h x i)		\$250,431	\$257,056
k. Claim Fluctuation Margin		1.01	1.01
l. Projected Experience Paid Claims with Margin (j x k)		\$252,935	\$259,626
m. Claim Rate	PEPM:	\$69.56	\$71.40
	Monthly:	\$21,078	\$21,636
	Annual:	\$252,935	\$259,626
	Credibility:	80%	20%
	PEPM Blended Rate:	\$69.93	



Sample Client
Medical, Pharmacy, Dental and Vision Funding Projection For a July 1, 2023 Effective Date
— Vision Claims Projection —

1. Objective Develop funding rates which cover all vision paid claims and associated administrative expenses.

2. Assumptions

a. Vision Trend:	1.50%	(Segal 2023)	Months of Trend:	Year 1 19	Year 2 31
b. Enrollment:	Lagged 2 months				
c. Experience:	Per experience reports provided by Summit				
d. Pooled Claims:	N/A				
e. Benefit Changes:	2022/2023: No plan changes		2021/2022: No plan changes		
	2020/2021: No plan changes		2019/2020: No plan changes		
	Year 1 = 1.000, Year 2 = 1.000				
f. Other Load/Decrement:	0.0%	COVID -19 Impact Load due to pent-up demand			
g. Fluctuation Margin:	1.0%				
h. Current Enrollment:	303	(January 2023)			

3. Algorithm

	Year 1	Year 2
Paid Period:	2/1/22 - 1/31/23	2/1/21 - 1/31/22
Incurred Period:	12/1/21 - 11/30/22	12/1/20 - 11/30/21
Midpoint:	6/1/2022	6/1/2021
Average Enrollment:	297	284
a. Vision Paid Claims	\$21,565	\$16,570
b. Change in Reserve (Lagged Claims)	1.000	1.000
c. Network Change	1.000	1.000
d. Adjusted Paid Claims (a x b x c)	\$21,565	\$16,570
e. Trend Adjustment Factor	1.024	1.039
f. Trended Adjusted Paid Claims (d x e)	\$22,079	\$17,220
g. Plan Change Adjustment Factor	1.000	1.000
h. Enrollment Change Adjustment Factor	1.020	1.067
i. COVID-19 Impact Load	1.00	1.00
j. Projected Experience Paid Claims (f x g x h x i)	\$22,532	\$18,367
k. Claim Fluctuation Margin	1.01	1.01
l. Projected Experience Paid Claims with Margin (j x k)	\$22,757	\$18,550
m. Claim Rate	PEPM: \$6.26 Monthly: \$1,896 Annual: \$22,757	\$5.10 \$1,546 \$18,550
Credibility:	80%	20%
PEPM Blended Rate:	\$6.03	

Sample Client

Medical, Pharmacy, Dental and Vision Funding Projection For a July 1, 2023 Effective Date — Medical, Pharmacy, Dental, Vision Rate Change —

a. Current Enrollment (January 2023)

	<u>PPO 500</u>	<u>Totals</u>
Employee Only	138	138
Employee + Family	<u>165</u>	<u>165</u>
Total	303	303

b. 2022/2023 Funding Rates (Includes Credit from Trust Reserve)

	<u>PPO 500</u>
Employee Only	\$481.70
Employee + Family	\$1,232.49

c. Total Current 2022/2023 Funding

	<u>PPO 500</u>	<u>Totals</u>
Employee Only	\$66,475	\$66,475
Employee + Family	<u>\$203,361</u>	<u>\$203,361</u>
Total Monthly	\$269,835	\$269,835

PEPM Funding:	\$890.55
Monthly Funding:	\$269,835
Annual Funding:	\$3,238,025

d. Percent Change in Funding Rates

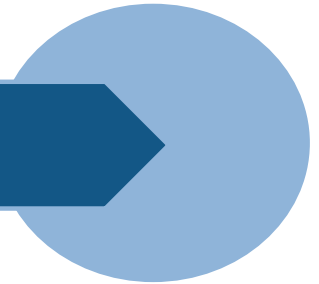
Current PEPM Funding:	\$890.55		<u>Med Claims</u>	<u>Rx Claims</u>	<u>Dental Claims</u>	<u>Vision Claims</u>	<u>Admin</u>	<u>Stop Loss</u>
Projected PEPM Funding:	\$850.19	=====>	\$529.31	\$65.08	\$69.93	\$6.03	\$71.79	\$108.05
Calculated Rate Action:	-4.53%	Px Breakdown	62.3%	7.7%	8.2%	0.7%	8.4%	12.7%
Recommended Rate Action:	0.00%		\$670.35					
% Claims:			78.8%					

e. **Forecasted 2023/2024 Funding Rates With No Plan Changes**

	<u>PPO 500</u>
Employee Only	\$481.70
Employee + Family	\$1,232.49
Renewal PEPM Funding:	\$890.55
Renewal Monthly Funding:	\$269,835
Renewal Annual Funding:	\$3,238,025.40



Section 3: Fixed Cost Assumptions



Sample Client

Medical, Pharmacy, Dental and Vision Funding Projection For a July 1, 2023 Effective Date — Fixed Cost Assumptions —

PEPM Fixed Costs				
	2022/2023	Estimated 2023/2024	% Change	Estimated Annual 2023/2024
Subscribers	303	303		
Medical Administration Fee ³	\$20.15	\$20.15	0.0%	\$73,265
Network Access Fee ³	\$21.25	\$21.25	0.0%	\$77,265
Mexico Medical Access Fee - IMS	\$3.00	\$3.00	0.0%	\$10,908
Vision Admin Fee	\$0.80	\$0.80	0.0%	\$2,909
Medicare Reporting	\$1.00	\$1.00	0.0%	\$3,636
Acct/BankRec/Financials	\$3.20	\$3.20	0.0%	\$11,635
Utilization Review	\$2.55	\$2.55	0.0%	\$9,272
No Surprise Act	\$0.50	\$1.00	100.0%	\$3,636
Wellness Administration	\$6.19	\$6.19	0.0%	\$22,500
Individual Stop Loss ^{1,2}	\$88.16	\$103.16	17.0%	\$375,093
Aggregate Stop Loss	\$4.57	\$4.89	7.0%	\$17,780
Consulting Fee	<u>\$12.65</u>	<u>\$12.65</u>	0.0%	<u>\$46,000</u>
Total Fixed Costs	\$164.02	\$179.84	9.6%	\$653,899

¹ \$125,000 ISL deductible with \$0 aggregating deductible, 125% aggregate corridor, 48/12 contract

² Estimated increase of 17% on ISL and 7% on ASL.

³ Medical & Network Admin Fee received 0% increase.

PEPM ACA Fees				
	2022/2023	Estimated 2023/2024	% Change	Estimated Annual 2023/2024
Subscribers	303	303		
Members	736	736		
PCORI Fee ^{2,3}	\$0.59	\$0.61	3.4%	\$2,218

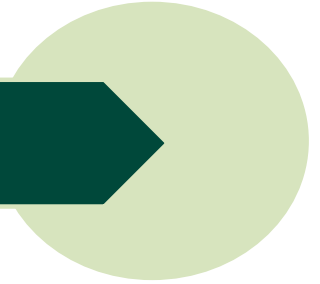
² IRS PCORI fee for plan years ending on or before 9/30/2023 is \$2.90 PMPY. The projected rate for the plan year ending 6/30/2024 is \$3.02, indexed at 4%.

³ ERISA exempt, therefore the PCORI fees are included in premium equivalent rates.

PEPM Fixed Costs and ACA Fees				
	2022/2023	Estimated 2023/2024	% Change	Estimated Annual 2023/2024
Total Fixed Costs and ACA Fees	\$164.61	\$180.45	9.6%	\$656,117



Section 4: Claims and Enrollment Data



Sample Client
Medical, Pharmacy, Dental and Vision Funding Projection For a July 1, 2023 Effective Date
— Claims and Enrollment Data —

	Month	PPO 500		Total		Medical PPO 500	Pharmacy PPO 500	Dental	Vision	Total
		Subs	Members	Subs	Members	Paid Claims	Paid Claims	Paid Claims	Paid Claims	Paid Claims
Year 2	Dec-20	279	766	279	766	\$115,779	\$35,424	\$7,742	\$822	\$159,767
	Jan-21	282	775	282	775	\$173,473	\$42,920	\$15,766	\$1,080	\$233,239
	Feb-21	279	758	279	758	\$90,685	\$28,800	\$13,231	\$2,425	\$135,142
	Mar-21	285	772	285	772	\$123,148	\$42,628	\$18,719	\$1,036	\$185,532
	Apr-21	280	757	280	757	\$129,393	\$44,233	\$13,097	\$1,566	\$188,289
	May-21	284	763	284	763	\$201,843	\$47,372	\$18,076	\$1,432	\$268,723
	Jun-21	280	757	280	757	\$119,420	\$57,220	\$26,173	\$1,120	\$203,933
	Jul-21	279	729	279	729	\$233,888	\$43,644	\$23,367	\$1,250	\$302,149
	Aug-21	285	739	285	739	\$89,676	\$33,168	\$11,870	\$780	\$135,494
	Sep-21	289	741	289	741	\$183,696	\$16,750	\$24,229	\$2,227	\$226,903
	Oct-21	292	746	292	746	\$106,849	\$21,676	\$9,543	\$1,439	\$139,507
	Nov-21	295	749	295	749	\$88,259	\$30,585	\$16,860	\$519	\$136,223
Year 1	Dec-21	295	752	295	752	\$106,517	\$18,764	\$28,232	\$1,140	\$154,653
	Jan-22	292	747	292	747	\$299,862	\$16,233	\$14,387	\$1,635	\$332,117
	Feb-22	293	755	293	755	\$152,633	\$12,784	\$17,519	\$1,239	\$184,175
	Mar-22	301	752	301	752	\$138,462	\$18,721	\$23,447	\$1,478	\$182,109
	Apr-22	300	749	300	749	\$104,600	\$24,744	\$10,774	\$1,853	\$141,972
	May-22	296	742	296	742	\$112,796	\$27,613	\$15,833	\$1,283	\$157,524
	Jun-22	297	732	297	732	\$108,129	\$5,915	\$26,018	\$2,278	\$142,340
	Jul-22	298	740	298	740	\$121,274	\$16,014	\$9,892	\$1,829	\$149,009
	Aug-22	296	773	296	773	\$209,884	\$29,705	\$14,082	\$2,428	\$256,098
	Sep-22	302	735	302	735	\$146,022	\$22,688	\$15,377	\$3,667	\$187,754
	Oct-22	296	723	296	723	\$129,852	\$24,282	\$23,007	\$1,030	\$178,171
	Nov-22	297	726	297	726	\$168,383	\$19,706	\$29,655	\$1,972	\$219,716
	Dec-22	303	736	303	736	\$167,437	\$20,412	\$11,017	\$830	\$199,697
	Jan-23	303	736	303	736	\$63,137	\$8,097	\$34,006	\$1,677	\$106,917

USED IN PROJECTION: Approximation of Incurred Claims: Medical, Rx, Dental & Vision Paid from February 2022 through January 2023 (2 months lag).

YEAR 1					Medical PPO 500	Pharmacy PPO 500	Dental	Vision	Total
	PPO 500		Total		Paid Claims	Paid Claims	Paid Claims	Paid Claims	Paid Claims
	Subs	Members	Subs	Members					
RESULTS:	3,563	8,926	3,563	8,926	\$1,622,608	\$230,682	\$230,627	\$21,565	\$2,105,482
Monthly:	297	744	297	744	\$135,217.34	\$19,223.49	\$19,218.90	\$1,797.09	\$175,456.82
PEPM:					\$455.41	\$64.74	\$64.73	\$6.05	\$590.93
									*Adjusted for Large Claims= \$590.93

USED IN PROJECTION: Approximation of Incurred Claims: Medical, Rx, Dental & Vision Paid from February 2021 through January 2022 (2 months lag).

YEAR 2					Medical PPO 500	Pharmacy PPO 500	Dental	Vision	Total
	PPO 500		Total		Paid Claims	Paid Claims	Paid Claims	Paid Claims	Paid Claims
	Subs	Members	Subs	Members					
RESULTS:	3,409	9,052	3,409	9,052	\$1,773,237	\$401,073	\$217,785	\$16,570	\$2,408,665
Monthly:	284	754	284	754	\$147,769.71	\$33,422.74	\$18,148.75	\$1,380.86	\$200,722.06
PEPM:					\$520.16	\$117.65	\$63.89	\$4.86	\$706.56
									*Adjusted for Large Claims= \$586.97

PEPM percent change	4.52%	-1.39%	4.52%	-1.39%	-12.45%	-44.97%	1.32%	24.52%	-16.37%
									Adjusted increase - w/o Large Claimants: 0.67%



Sample Client

Medical, Pharmacy, Dental and Vision Funding Projection For a July 1, 2023 Effective Date

Year 1: Large Claims > \$125,000 (Paid February 2022 - January 2023):

	<u>Claims</u>	<u>ISL Trigger</u>	<u>Approx Recovery</u>
Claimant 1	\$0	\$0	\$0
Claimant 2	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>
Total	\$0	\$0	\$0

Year 2: Large Claims > \$125,000 (Paid February 2021 - January 2022):

	<u>Claims</u>	<u>ISL Trigger</u>	<u>Approx Recovery</u>
Claimant 1	\$281,970	\$125,000	\$156,970
Claimant 2	<u>\$125,700</u>	<u>\$125,000</u>	<u>\$700</u>
Total	\$407,670	\$250,000	\$157,670



Sample Incurred But Not Reported Estimates as of September 30, 2020

CBIZ Benefits & Insurance Services, Inc. prepared an estimate of the claims incurred but not yet paid for Client's benefit plan as of September 30, 2020. We recommend that Client hold the following IBNR reserve:

	Claims IBNR Estimates	Claims Processed But Not Cleared Bank Account	Final Reserve Estimate
Medical/Rx	\$644,044	\$58,100	\$702,144

In making the estimation, CBIZ relied upon the following information:

- ▶ Paid claims lag reports, based on incurred dates 10/1/18 - 9/30/20
- ▶ Large claim reports, 10/1/18 - 9/30/20

There were 4 individuals with claims greater than the stop loss deductibles of \$200,000 ISL. Therefore \$775,715 was removed in the determination of the final reserve estimate.

Other information that may be pertinent to the claim valuation was not requested from Client and/or UMR, MagellanRx and PayerMatrix. Information of note is as follows (if you feel any of these need to be taken into consideration at this time, please discuss with your CBIZ Account Management Team):

- ▶ Monthly enrollment reports
- ▶ Administrative and Stop Loss data
- ▶ Computer system conversion and/or other conversions
- ▶ Contractual Arrangements: Information regarding claim run-out processing costs
- ▶ Liability for legal fees or consulting fees related to claim investigation and settlement
- ▶ Monthly Backlog and lost workdays
- ▶ Claims in the Course of Settlement
- ▶ The speed of payment

DEFINITIONS/NOTES:

- (1) Run-off: The progression of remaining claims paid by the month incurred through the valuation period.
- (2) Claim Reserve Relative Range: The lowest and highest run-off amount by month through the valuation period.
- (3) Medical/Rx Claims IBNR Reserve Estimate: The high end of the reserve range at the 80th percentile
- (4) Claims Processed But Not Cleared Bank Account: Accounts for the lag between when a claim is reported as paid by the vendor versus actual physical withdrawal from Client's bank account. The number of outstanding days can be modified.

**This information was provided from Client's claim payer, UMR, MagellanRx and PayerMatrix and/or from Client.
Full reliance on the accuracy of this data was placed on these parties.**



Sample

Incurring But Not Reported (IBNR)

Medical and Pharmacy

INCURRED: 10/1/18 - 9/30/20

Valuation Date: September 30, 2020

Manual adjustment to remove claims above \$200,000 ISL of

\$775,715

PAID ↓	INCURRED →																							Pd Claims	Cumm Pd Claims Per		
	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20			
Oct-18	162,711																								\$162,711	\$162,711	Oct 18
Nov-18	203,546	145,787																							\$349,333	\$512,044	Nov 18
Dec-18	68,416	184,318	96,675																						\$349,409	\$861,453	Dec 18
Jan-19	12,419	6,004	169,904	136,170																					\$324,497	\$1,185,950	Jan 19
Feb-19	47,005	73,583	43,603	151,243	112,845																				\$428,278	\$1,614,228	Feb 19
Mar-19	350	8,789	3,049	63,516	173,016	93,485																			\$342,205	\$1,956,433	Mar 19
Apr-19	20,051	4,438	2,474	13,258	32,752	197,254	150,298																		\$420,525	\$2,376,958	Apr 19
May-19	291	(910)	(243)	79,050	93,857	42,643	198,725	158,965																	\$572,377	\$2,949,335	May 19
Jun-19	1,444	850	68	1,254	5,565	7,627	89,652	197,632	136,131																\$440,222	\$3,389,557	Jun 19
Jul-19	3,187	(598)	0	181	241	23,432	96,348	62,635	195,572	152,375															\$533,373	\$3,922,930	Jul 19
Aug-19		65	3,942	16,216	11,672	15,093	34,750	7,009	109,187	293,533	145,542														\$637,011	\$4,559,941	Aug 19
Sep-19	0	57	0	1,114	372	528	218	5,109	12,703	57,331	215,759	121,891													\$415,082	\$415,082	Sep 19
Oct-19	0	(61)	(658)	2,327	413	22,033	877	649	24,693	30,089	95,550	246,749	192,217												\$614,878	\$1,029,960	Oct 19
Nov-19	0	0	0	0	2,756	2,740	2,422	3,169	4,872	8,062	10,474	70,526	180,461	138,783											\$424,264	\$1,454,224	Nov 19
Dec-19	0	0	77	5,685	8,594	(52)	73	954		(771)	263	225,496	21,657	153,954	186,029										\$601,957	\$2,056,181	Dec 19
Jan-20		0	0	97	770	505	469	10,301	608	2,444	888	(200,901)	7,307	78,735	214,582	155,322									\$271,127	\$2,327,308	Jan 20
Feb-20		44	0	0	0	126		2,309	1,094	0	(235)	48	73,792	28,306	20,952	178,589	119,329								\$424,354	\$2,751,662	Feb 20
Mar-20	0				200	250	159	0	698	7,108	0	117,871	67,705	52	6,004	86,884	199,852	204,361							\$691,146	\$3,442,808	Mar 20
Apr-20		0					0	1,518	(4)	0	1,040	0	11,884	712	264	16,009	63,078	190,887	103,189						\$388,579	\$3,831,386	Apr 20
May-20	0	0	0	0			0	7		750	0	289	0	338	14,706	21,684	28,938	79,022	188,467	67,465					\$402,173	\$4,233,559	May 20
Jun-20				0		0	1,162			0	185	30	8,847	13,412	23,356	9,958	4,012	28,478	70,843	219,412	201,965				\$581,660	\$4,815,219	Jun 20
Jul-20	0			107				0		142	0	296	11	164	453	218	21,869	11,873	52,362	87,563	161,232	162,049			\$498,340	\$498,340	Jul 20
Aug-20			0	(107)		0	1,775					(2,287)	16,234	8,573	7,149	5,758	0	1,343	17,271	14,919	52,375	193,959	136,480		\$453,443	\$951,782	Aug 20
Sep-20	0	0	0	(5,671)			0	0	0	0	0	0	0	0	88	190	0	3,127	0	19,913	18,154	24,053	134,512	165,013	\$359,379	\$1,311,162	Sep 20
Total	519,420	422,306	318,948	464,441	443,054	405,666	576,929	450,256	486,061	551,063	469,465	580,008	580,115	423,030	473,583	474,613	437,077	519,091	432,133	409,272	433,726	380,062	270,992	165,013	10,686,322		

ACTUAL RUN-OFF CLAIM DEVELOPMENT																									Run Off Thru		
Run-Off @	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Val Date by Mos		
Oct 18	356,709																								356,709	Oct 18	
Nov 18	153,163	276,520																							429,682	Nov 18	
Dec 18	84,747	92,201	222,273																						399,221	Dec 18	
Jan 19	72,328	86,198	52,368	328,271																					539,165	Jan 19	
Feb 19	25,323	12,615	8,766	177,028	330,209																				553,941	Feb 19	
Mar 19	24,973	3,826	5,717	113,512	157,193	312,180																			617,402	Mar 19	
Apr 19	4,922	-611	3,243	100,254	124,441	114,926	426,631																		773,805	Apr 19	
May 19	4,631	299	3,486	21,204	30,584	72,283	227,906	291,291																	651,684	May 19	
Jun 19	3,187	-551	3,418	19,950	25,019	64,656	138,254	93,659	349,929																697,522	Jun 19	
Jul 19	0	48	3,418	19,769	24,778	41,224	41,905	31,024	154,357	398,688															715,212	Jul 19	
Aug 19	0	-17	-524	3,553	13,105	26,131	7,155	24,015	45,170	105,155	323,923														547,666	Aug 19	
Sep 19	0	-17	-581	2,439	12,733	25,603	6,937	18,906	32,468	47,824	108,164	458,117													712,592	Sep 19	
Oct 19	0	44	77	111	12,320	3,570	6,060	18,257	7,775	17,735	12,614	211,368	387,898												677,829	Oct 19	
Nov 19	0	44	77	111	9,565	830	3,638	15,088	2,903	9,673	2,140	140,842	207,437	284,247											676,595	Nov 19	
Dec 19	0	44	0	-5,573	970	882	3,565	14,134	2,903	10,444	1,877	-84,654	185,780	130,294	287,554										548,221	Dec 19	
Jan 20	0	44	0	-5,671	200	377	3,096	3,834	2,295	8,000	990	116,248	178,473	51,558	72,972	319,291									751,707	Jan 20	
Feb 20	0	0	0	-5,671	200	250	3,096	1,525	1,201	8,000	1,225	116,200	104,681	23,252	52,021	140,702	317,749								764,430	Feb 20	
Mar 20	0	0	0	-5,671	0	0	2,937	1,525	503	892	1,225	-1,672	36,976	23,200	46,016	53,818	117,896	314,730							592,375	Mar 20	
Apr 20	0	0	0	-5,671	0	0	2,937	7	507	892	185	-1,672	25,092	22,488	45,752	37,808	54,818	123,843	328,943						635,929	Apr 20	
May 20	0	0	0	-5,671	0	0	2,937	0	0	142	185	-1,961	25,092	22,149	31,046	16,124	25,880	44,821	140,476	341,808					643,029	May 20	
Jun 20	0	0	0	-5,671	0	0	1,775	0	0	142	0	-1,991	16,245	8,737	7,690	6,166	21,869	16,343	69,633	122,395	231,761				495,095	Jun 20	
Jul 20	0	0	0	-5,778	0	0	1,775	0	0	0	0	-2,287	16,234	8,573	7,238	5,948	0	4,470	17,271	34,832	70,529	218,012			376,817	Jul 20	
Aug 20	0	0	0	-5,671	0	0	0	0	0	0	0	0	0	0	88	190	0	3,127	0	19,913	18,154	24,053	134,512		194,366	Aug 20	
Sep 20	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	Sep 20

.	Claim Reserve Relative Range	\$194,366	to	\$773,805
.	Medical/Rx Claims IBNR Reserve Estimate	\$619,044		
.	Claims Fluctuation Adjustmen	\$25,000	Ongoing large claims and potential COVID pent up demand releas	
.	Medical/Rx Claims Processed But Not Clearec Bank Account	\$58,100	(3 Day Estimate)	
.	Final Total Medical/Rx Reserve Estimate	\$702,144		



SECTION 3

RENEWAL TIMELINE SAMPLE

Sample

2023 Marketing & Renewal Timeline



QUARTER	ACTIVITIES / DELIVERABLES	DUE DATE	RESPONSIBLE PARTY(IES)
Q1 2023 Mar	- Contract awarded to CBIZ - Initial 'get acquainted" meeting to review Scope of Services and expectations - Obtain and review current plan documents, rates, costs and CLIENT's medical insurance reporting package - Carrier calls to discuss plans, renewal history and current plan performance - Pre-renewal meeting to discuss strategy and determine need to issue RFPs - Issue RFPs to marketplace – if needed - Obtain renewals from carriers not required to be bid - Begin gathering letters of instruction for CBIZ data warehouse for regular reporting - Begin building monthly reports in CBIZ's formats - Monthly: - Monthly medical, Rx and dental financial reporting - Quarterly IBNR estimates - Regulatory updates "Benefit Beat" and Healthcare Reform Bulletins - Wellness Insights newsletters	Mid Mar Mid Mar Late Mar Late Mar Mid Mar Late Mar	CLIENT CBIZ/CLIENT CBIZ/Carriers CBIZ/CLIENT/ CBIZ CBIZ/CLIENT CBIZ CBIZ CBIZ CBIZ
Q2 2023 Apr May Jun	- Review RFP submissions and begin scoring - Meet to make carrier/vendor selection recommendations - Meet with Selection Committee to make carrier/vendor selection - Notify carrier(s)/vendor(s) of awards - Develop initial contribution and funding strategies - Begin implementation of any new carriers or plans - Open enrollment/communication strategy development - Finalize open enrollment communication - Quarterly claims utilization meeting - Open enrollment meetings begin - Enrollment elections finalized with carriers - Monthly: - Monthly medical, Rx and dental financial reporting - Quarterly IBNR estimates - Quarterly disease management review - Regulatory updates "Benefit Beat" and Healthcare Reform Bulletins - Wellness Insights newsletters	Early Apr Mid Apr Late Apr Late Apr Late Apr Early May Early May Mid May Late May Late May Early Jun Mid Jun	CBIZ/CLIENT CBIZ/CLIENT CBIZ CBIZ/CLIENT CBIZ/CLIENT CBIZ/CLIENT CBIZ/CLIENT CBIZ/CLIENT CBIZ/CLIENT CBIZ/CLIENT CBIZ/CLIENT CBIZ/CLIENT CBIZ
Q3 2023 Jul Aug Sep	- Review post renewal enrollments - Quarterly claims utilization and Premium Adequacy Report meeting - Monthly: - Monthly medical, Rx and dental financial reporting - Quarterly IBNR estimates - Quarterly disease management review - Regulatory updates "Benefit Beat" and Healthcare Reform Bulletins - Wellness Insights newsletters	Late Jul Early Sep	CBIZ CBIZ/CLIENT CBIZ

SAMPLE

2023 Marketing & Renewal Timeline



QUARTER	ACTIVITIES / DELIVERABLES	DUE DATE	RESPONSIBLE PARTY(IES)
Q4 <u>2023</u> Oct Nov Dec	- Quarterly claims utilization and 2023 pre-renewal meeting - Monthly: - Monthly medical, Rx and dental financial reporting - Quarterly IBNR estimates - Quarterly disease management review - Regulatory updates “Benefit Beat” and Healthcare Reform Bulletins - Wellness Insights newsletters	Early Dec	CBIZ/CLIENT CBIZ
As Needed/ Ongoing	- Client service support - Claim resolution support - Billing & eligibility support - Compliance calls		CBIZ



SECTION 3

ANNUAL PERFORMANCE REVIEW DOCUMENT

Plan Year 2021 - 2022
**ANNUAL
PERFORMANCE
REVIEW**



Sample Client

December 7, 2022



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2021-2022 Renewal Reviews

Medical UnitedHealthcare	- Final negotiated renewal released with an overall 5.4% increase / \$213,117 maximum liability (fixed + claims) increase. Total annual maximum liability \$4,170,915 - Fixed Fees - Administrative fee: as negotiated for the 2019/2020 plan year, UHC issued a fee rate increase of 3% / \$66.19 PEPM, estimated annual expense \$231,135, an increase of \$6,740. - Stop Loss Premiums: increase of 12.7%, estimated annual expense of \$413,104, an increase of \$46,653. ISL – the Client elected to remove the Experience Refund Endorsement rider. The rate renewed at \$109.33 PEPM, an increase of 12.5%, estimated annual expense of \$381,780, an increase of \$45,326. ASL - renewed at a rate of \$8.97 PEPM, an increase of 4.4%, estimated annual expense of \$31,323, an increase of \$1,397. - Maximum Claim Projection: 4.7% increase, estimated annual expense of \$3,526,676, an increase of \$159,724. - CBIZ's Funding Projection: 2.9% decrease under the 2020-2021 implemented rates - Client moved forward with a premium funding rate pass. - Approved Town's Know Your Numbers contribution share with employees: - PPO – EE Only – 85% Client / 15% Employee EE + Dependent Tiers – 75% Client / 25% - Employee - HDHP – EE Only – 100% Client / 0% Employee EE + Dependent Tiers – 80% Client / 20% Employee - Know Your Numbers \$30/month incentive continued. - Client HSA contributions of \$1,000 Employee / \$1,750 Employee + Dependent tiers continued. - Benefit plan changes on both plans: - Added telehealth services (consults by a PCP/Specialist physicians to a covered member). - Added Naviguard, replaced the Shared Savings program. - UHC program enhancements - Focused Claim Review, Living with Diabetes, and AbleTo. - Terminated the Quit for Life and Real Appeal programs.
Dental Delta Dental	- Final negotiated renewal increase of 5% with a rate guarantee through June 30, 2022. - Benefits continued with Delta Dental.
Vision EyeMed	- In rate guarantee through June 30, 2022. - Benefits continued with EyeMed.

2021-2022 Renewal Reviews



Basic Life/Voluntary Life/Long Term Disability Mutual of Omaha

- Renewal released with a 1 year rate pass through June 30, 2022.
- Benefits continued with Mutual of Omaha.

Short Term Disability Mutual of Omaha

- In rate guarantee through June 30, 2022.
- Benefits continued with Mutual of Omaha.

Employee Assistance Program Jorgensen Brooks Group

- In rate guarantee through June 30, 2022.
- Benefits continued with Jorgensen Brooks Group.

Voluntary Benefits Colonial

- Benefits continued with Colonial.

Prepaid Legal & ID Shield LegalShield

- Benefits continued with LegalShield.

Flexible Benefits Administration CBIZ Flex

- Benefits continued with CBIZ Flex.

COBRA Administration CBIZ COBRA

- Benefits continued with CBIZ COBRA.

Medical Projected Enrollment and Cost Review



<i>Projected Enrollment</i>	2021/2022	2020/2021	2019/2020
PPO Plan	193	210	231
High Deductible Health Plan	101	73	72
Average Monthly Enrollment Totals	294	283	303
% In HDHP Plan	34.4%	25.8%	23.8%

Annual Funding Projection Estimate	\$3,488,170	\$2,863,691	\$3,699,049
Funding Projection PEPM	\$988.71	\$843.25	\$1,017.34
Year Over Year Projected \$ Change	\$624,479	-\$835,358	
Year Over Year Projected % Change	21.8%	-22.6%	
Actual Annual Claims, Admin, Consulting	\$2,870,755	\$3,138,196	\$2,536,245
Actual Annual Claims, Admin, Consulting PEPM	\$813.71	\$924.09	\$697.54
Annual Reserve Savings/Deficit Estimate	\$617,415	-\$274,505	\$1,162,804

Medical Actual Enrollment and Budget Cost Review



Actual Enrollment	2021/2022	2020/2021	2019/2020
PPO Plan	182	194	213
High Deductible Health Plan	115	99	76
Average Monthly Enrollment Totals	297	293	289
% In HDHP Plan	38.7%	33.8%	26.3%

Annual <u>Budget</u> Estimate	\$3,458,866	\$3,486,447	\$3,533,847
Annual <u>Budget</u> PEPM	\$970.50	\$991.59	\$1,018.99
Actual Annual Claims, Admin, Consulting	\$2,870,755	\$3,138,196	\$2,536,245
Actual Annual Claims, Admin, Consulting PEPM	\$805.49	\$892.55	\$731.33
Annual Reserve Saving/Deficit Estimate	\$588,111	\$348,251	\$997,602

Year Over Year Annual Cost \$ Change	-\$267,441	\$601,951	
Year Over Year Annual Cost % Change	-8.5%	23.7%	

HSA Contributions	\$164,229	\$137,688	\$83,896

Actual Annual Claims, Admin, Consulting, & HSA Contributions	\$3,034,984	\$3,275,884	\$2,620,141
Annual Reserve Saving/Deficit Estimate	\$423,882	\$210,563	\$913,706
Year Over Year Annual Cost \$ Change	-\$240,900	\$655,743	
Year Over Year Annual Cost % Change	-7.4%	25.0%	

UnitedHealthcare Reconciliation & Rebates

- UnitedHealthcare's reconciliation results:
 - Bank Account Adjustments - \$0
 - Administration Fees and Stop Loss Premiums – \$0
 - Performance Guarantee metrics met - \$0
 - Pharmacy Discounts, Fees, Rebates, Specialty metrics not met –\$1,248
 - **TOTAL DUE TO Sample Client1,248**

See Section 8 for report details

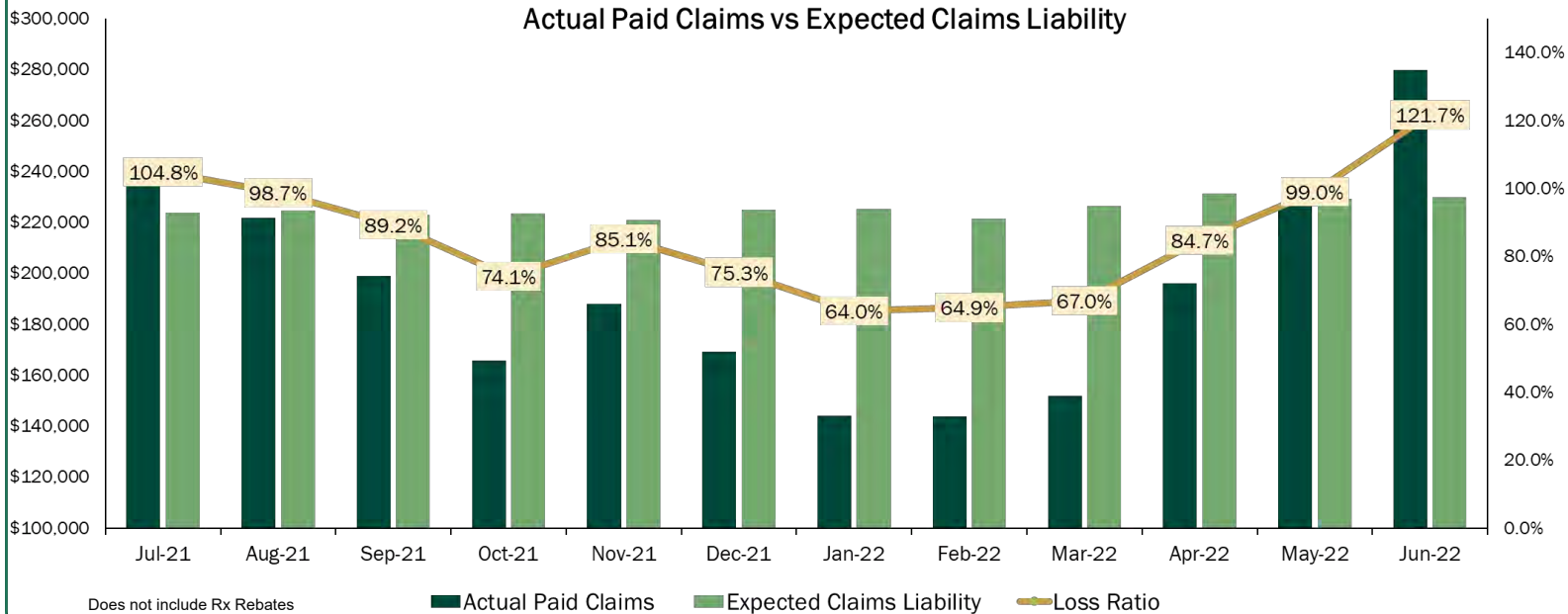
- Pharmacy Rebates
 - \$148,421 / \$41.64 PEPM

Claims Dashboard

FINANCIALS

PLANS	2021/2022			2020/2021			Annual Trend
	Subscribers	Loss Ratio at Expected Liability	Paid Claims PEPM	Subscribers	Loss Ratio at Expected Liability	Paid Claims PEPM	
PPO Plan	182	96.6%	\$841	194	127.2%	\$968	-13.1%
High Deductible Health Plan	115	60.1%	\$350	99	58.8%	\$264	32.4%
Summary	297	80.3%	\$610	293	108.6%	\$712	-14.3%

Actual Paid Claims vs Expected Claims Liability



HIGH COST CLAIMANTS

# of High Cost Claimants over \$50,000	# of High Cost Claimants Over \$150,000	Total Paid Over \$150,000 (Individual Stop Loss)
6	0	\$0

Top High Cost Claimant Diagnosis		Top Diagnostic Categories	
Saddle embolus of pulmonary artery without acute cor pulmonale	\$97,768	Nervous System	\$234,122
Autoimmune hemolytic anemia, unspecified	\$84,299	Musculoskeletal	\$221,080
Multiple sclerosis	\$71,412	Other Conditions	\$201,277
Chronic migraine without aura	\$69,574	Infections & Parasitic Diseases	\$140,284
Other Diagnosis	\$60,112	Gastroenterology	\$133,366

Claims Dashboard



CLAIMS COST						
	2021/2022	2020/21	2019/20	2021/2022	2020/21	2019/20
	TOTAL	TOTAL	TOTAL	PEPM	PEPM	PEPM
Plan Paid						
Medical	\$1,682,794	\$2,154,781	\$1,606,168	\$472.43	\$613.55	\$462.47
Pharmacy	\$637,425	\$612,532	\$641,984	\$178.95	\$174.41	\$184.85
Total	\$2,320,220	\$2,767,313	\$2,248,153	\$651.38	\$787.96	\$647.32
Stop Loss Reimbursements	\$0	(\$174,022)	(\$200,710)	\$0.00	(\$49.55)	(\$57.79)
Plan Paid Total	\$2,320,220	\$2,593,291	\$2,047,442	\$651.38	\$738.41	\$589.53
Employee (Member) Cost Share						
Employee Cost Share Total	\$519,011	\$482,937	\$372,598	\$145.71	\$137.51	\$107.28
Employee Cost Share %	18%	16%	15%	18%	16%	15%

* Pharmacy does not include Rx Rebates

Claims Dashboard



PHARMACY

TOP DRUGS BY PLAN COST

2021/2022			2020/21			2019/20		
DRUG	PLAN COST	CLAIMANTS	DRUG	PLAN COST	CLAIMANTS	DRUG	PLAN COST	CLAIMANTS
Dupixent Pen	\$63,992	3	Otezla	\$54,018	1	Otezla	\$50,899	1
Trulicity	\$33,603	4	Stelara	\$36,094	1	Stelara	\$49,048	1
Jardiance	\$33,157	9	Dupixent	\$29,114	2	Humalog	\$36,541	5
Spravato	\$27,928	1	Descovy	\$27,448	1	Dupixent	\$35,100	1
Descovy	\$25,372	1	Tivicay	\$27,225	1	Mavyret	\$26,393	1

TOP DRUGS BY FILLS

2021/2022			2020/21			2019/20		
DRUG	PLAN COST	FILLS	DRUG	PLAN COST	FILLS	DRUG	PLAN COST	FILLS
Atorvastatin Calcium	\$2,007	249	Montelukast Sodium	\$127	106	Ventolin	\$5,085	120
Levothyroxine Sodium	\$725	224	Levothyroxine Sodium	\$301	86	Lisinopril	\$57	97
Losartan Potassium	\$484	192	Ventolin	\$3,410	80	Sumatriptan Succinate	\$25	89
Lisinopril	\$177	178	Amlodipine Besylate	\$27	80	Montelukast Sodium	\$49	72
Amlodipine Besylate	\$12	177	Amlodipine Besylate	\$10	62	Hydrochlorothiazide	\$198	63

Drug Use By Tier - Paid Benefits 2021/2022

Tier 1	\$70,289	Percent of Total by Paid Benefits 14.6% 45.6% 39.8% ■ Tier 1 ■ Tier 2 ■ Tier 3
Tier 2	\$192,323	
Tier 3	\$220,018	

Drug Use By Tier - Scripts Filled 2021/2022

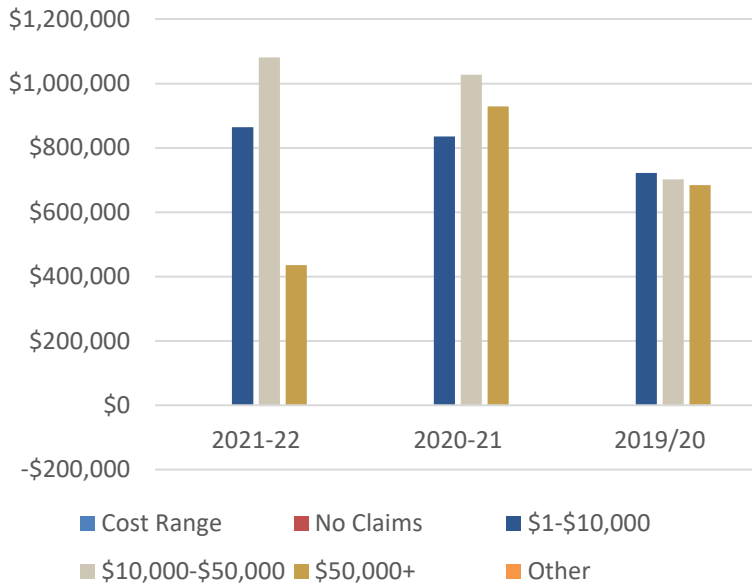
Tier 1	354	Percent of Total by Scripts Filled 23.9% 48.2% 27.9% ■ Tier 1 ■ Tier 2 ■ Tier 3
Tier 2	205	
Tier 3	176	

* Includes Rx Rebates

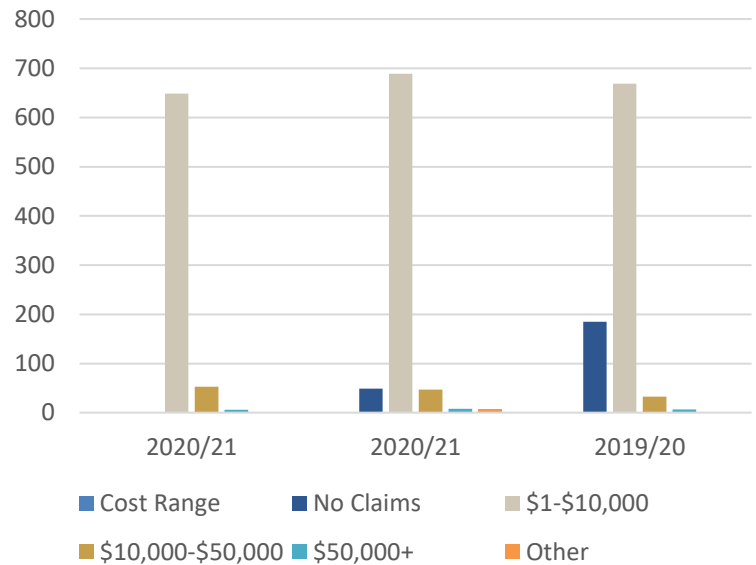
Claims Dashboard

Plan Paid and Members by Cost Range

Plan Paid Cost Range



of Members by Cost Range



PLAN PAID PER MEMBER

	2021/2022	2020/21	2019/20	2021/2022	2020/21	2019/20
Cost Range	Plan Paid/ % of Plan Paid	Plan Paid/ % of Plan Paid	Plan Paid/ % of Plan Paid	# of Members/ % of Enrolled Members	# of Members/ % of Enrolled Members	# of Members/ % of Enrolled Members
No Claims	\$0 0.00%	\$0 0.00%	\$0 0.00%	0 0.00%	49 6.13%	185 20.69%
\$1-\$10,000	\$864,000 36.30%	\$835,019 29.92%	\$721,652 34.22%	649 91.70%	689 86.13%	669 74.83%
\$10,000-\$50,000	\$1,080,748 45.40%	\$1,027,663 36.82%	\$702,541 33.31%	53 7.50%	47 5.88%	33 3.69%
\$50,000+	\$435,325 18.30%	\$928,554 33.27%	\$684,692 32.47%	6 0.80%	8 1.00%	7 0.78%
Other	\$0 0.00%	(\$568) -0.02%	\$0 0.00%	0 0.00%	7 0.88%	0 0.00%
Total*	\$2,380,073	\$2,790,669	\$2,108,885	708	800	894

*Stop Loss reimbursements not included

Onsite Clinic & COVID-19 Reviews

Onsite Clinic Cost Avoidance Review

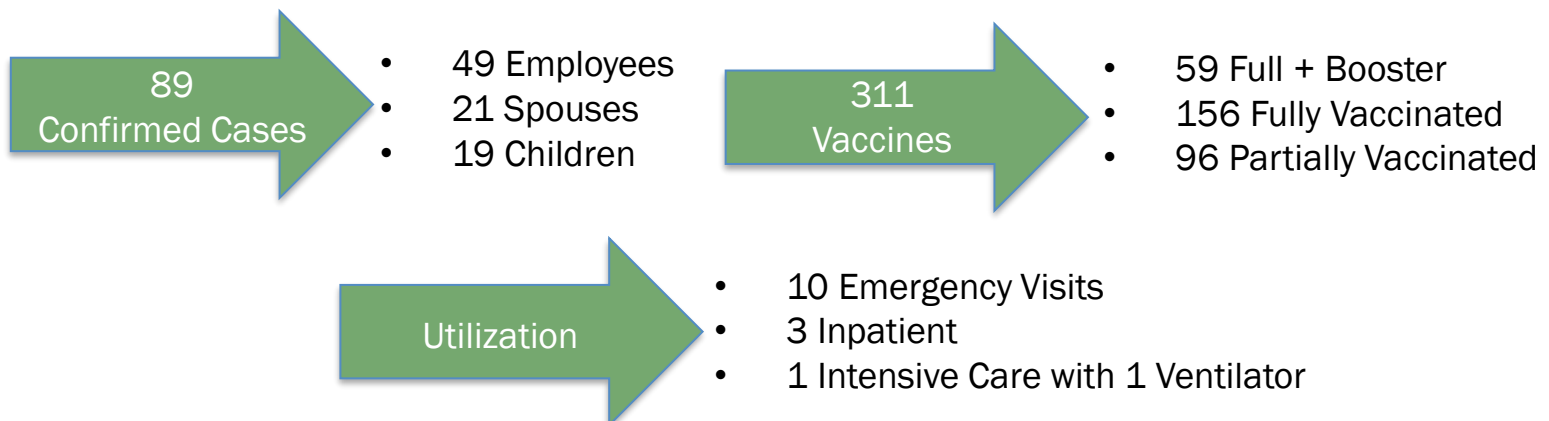
	Healthcare Solution Centers	United Healthcare	Difference
Annual Cost	\$155,384	\$114,928 (Market Average Reimbursement)	-\$40,456
Lost Work			\$126,600
Total Cost Avoidance Estimate			\$86,144

See Section 8 for report details

COVID-19 Review

Financial Summary by Incurred Year			
CLAIM TYPE	2020	2021	Total
Vaccines	\$183	\$18,261	\$18,444
Testing	\$17,475	\$26,417	\$43,892
Confirmed Diagnosis	\$30,741	\$56,053	\$86,794
TOTAL	\$48,400	\$100,731	\$149,130

Pandemic through December 2021



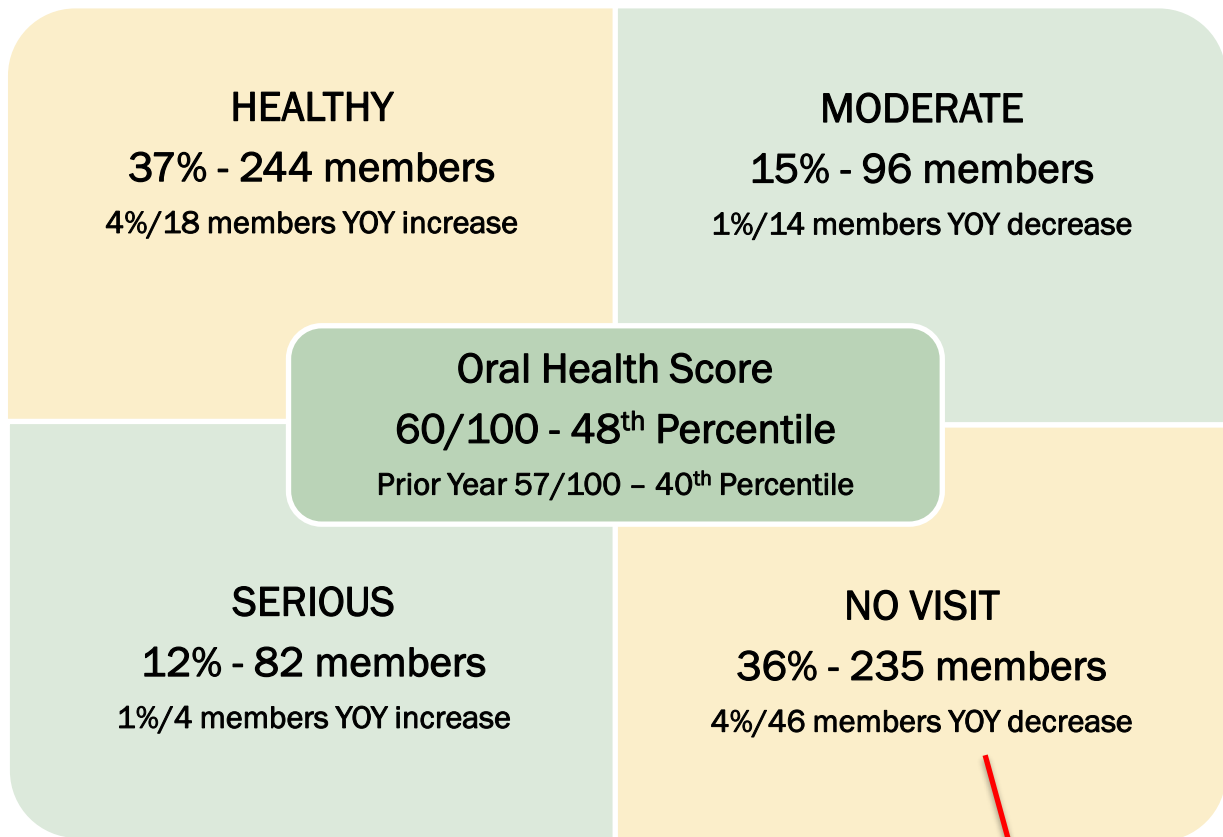
Dental Cost Review



Enrollment	2021/2022	2020/2021	2019/2020
Low Plan	224	230	237
High Plan	79	69	60
Average Monthly Enrollment Totals	303	299	297

Annual Premium	\$212,776	\$199,270	\$200,778
Annual Premium PEPM	\$58.52	\$55.54	\$56.34
Actual Annual Claims	\$155,601	\$166,645	\$155,221
Actual Annual Claims PEPM	\$42.79	\$46.45	\$43.55
Annual Difference	\$57,175	\$32,625	\$45,557
Loss Ratio	73.1%	83.6%	77.3%

Dental Highlights



Better than Peers:

- Period Maintenance
- Fluoride – Adults
- Fillings
- Crowns
- Root Canals
- Implants
- Dentures

Below Peers:

- Oral Exams
- Cleanings
- Sealants & Fluoride – Children
- Surg/Non Surg Perio Treatment

162 members have not seen a dentist for two years

- 132 adults
- 30 children

Employee Assistance Program

CLINICAL CARE

- 17 individuals / 4.2% (Prior Year 19 individuals/4.7%)
- Employee 58.8% / Spouse 5.9% / Dependents 35.3%
 - Females 64.7% / Males 35.3%
- Top Four Issues: Anxiety, Mental Health, Marital/Partner, Divorce/Separation

Economic Analysis and Calculation Table

The economic value of EAP services rendered is based upon the business costs associated with the specific problem suffered by the employee or their dependent. The actual business costs were derived from the most current and conservative research available.

Service Category	Number Clients	Category Costs	Economic Value
Mental Health			
Anger	1	\$2,608.71	\$2,608.71
Anxiety	4	\$2,608.71	\$10,434.84
Mental Health	4	\$2,608.71	\$10,434.84
Stress	1	\$2,869.58	\$2,869.58
Occupational			
Workplace Related	1	\$2,869.58	\$2,869.58
Relationships			
Child/Adolescent	1	\$3,375.00	\$3,375.00
Divorce and Separation	2	\$6,455.32	\$12,910.64
Family/Relationship	1	\$3,375.00	\$3,375.00
Marital and Partner	2	\$6,455.32	\$12,910.64
TOTALS	17		\$61,788.83

SOURCE: Data and economic analysis prepared by Jorgensen Brooks Group 2021/2022 reporting

Emerging Trends

Employer of Choice

- Incorporate benefits and policies that support the employer's goal of being a "Best Place to Work" and win the war for talent
- Design total rewards value proposition that includes outstanding employee experience
- Culture reflects core values and inspires meaning and purpose in employee work
- Mindfulness of racial and gender equity and inclusion

Provide Employee-Centric Environment

- Address flexible working arrangements
- Evaluate paid parental leave
- Work life integration strategies-balance complexity with compassion
- Provide valued benefits, with employee choice to purchase enhanced benefits to customize to employee needs
- Programs to support psychological & workplace safety for remote or hybrid work

Increase Employee Engagement

- Equitable access to resources regardless of employee location
- Targeted strategic communication with multi-channel options
- Provide decision support tools for employees to become informed health care consumers
- Integration of virtual health & in-person care

Outsourcing and Flexibility

- Leave management
- Health and wellbeing functions
- Unbundled third party administrator (TPA) services

Decrease Prevalence / Size of Extreme Claims

- Pharmacy advocacy and carve-outs
- Infusion and dialysis carve-outs
- Centers of Excellence (CoE) /Accountable Care Organizations (ACO)
- Second-opinion providers
- Condition specific programs
- Payment integrity/avoidance of fraud, waste, abuse

Cost Containment

- Reference based pricing
- Direct primary care and direct contracting
- Care Navigation & Health Care Support
- High performance networks/medical steerage
- Stop-loss captives

Cost Containment Strategies

Claims Administration, Network, and Stop Loss

Usually clients who “bundle” Health Innovations strategies will integrate at the SPD and TPA level. Therefore, finding the right “housing” agent for strategies is imperative, otherwise vendors may be incompatible.



KEY	OPTIONS
✓	Network-Owned TPA – UHC’s ChoicePlus Network
N/A	Network-Renting TPAs – UHC does not rent their network to non UnitedHealth Group TPAs
★	Carved out Stop Loss coverage

Care Coordination

Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. Integration is the combined set of methods, processes and models that seek to bring about this improved coordination of care.



KEY	OPTIONS
✓	Integrated Care Coordination
✓	Quasi-Integrated & Digital Care Coordination – Living with Diabetes, AbleTo, Kaia,
★	Non-Integrated Care Coordination
◆	Clinical Care Management & Health Coaching – Personal Health Support, AbleTo

Alternative (non-network) Funding Mechanisms

Strategies that either directly compete with a network offering or act as a function that is paid outside of the network arrangement.



KEY	OPTIONS
✗	Reference Based Pricing
✓	Accountable Care Organizations – built within UHC’s network
✓	Network Optimization Solutions
✗	Narrow Networks
★	Carve-Out Programs
✓	Direct Primary Care – Town’s onsite clinic
✓	Worksite or Nearsite Health Centers - Town’s onsite clinic
✓	Nearsite Fitness Centers – Oro Valley’s Community & Recreation Center

*Due to size, the Client may not qualify for programs.

✓	◆	★	✗
In place	Currently not in place, previously recommended	Recommended for evaluation	Trending but not recommended at this time

Cost Containment Strategies

Medical Point Solutions

Vendor partnerships that achieve a specific function in the healthcare delivery model that can function as a standalone deliverable or can be rolled up into an integrated care coordination model.



KEY	OPTIONS
✓	Medical Cost & Quality Data – Transparency rules
◆	2nd Opinion Programs – 2 nd MD, Grand Rounds
✓	Wellbeing Programs & Platforms – Wellness Council of Arizona
✓	Condition-Specific Programs – Kaia musculoskeletal, Alliance Work Partner PTX musculoskeletal
✓	Gym & Fitness Programs - Oro Valley's Community & Recreation Center
✓	Behavioral Health Programs & Platforms – Alliance Work Partners, UHC's Sanvello, Talkspace, & AbleTo programs

Pharmacy & Pharmacy Point Solutions

This includes all concepts and categories related to the procurement of medications.



KEY	OPTIONS
✓	Pharmacy & Pharmacy Point Solutions
✓	Narrow Networks
★	Pharmacy Benefit Coalitions
★	Alternative Pharmacy Procurement – Payor Matrix

*Due to size, the Client may not qualify for programs.

✓	◆	★	✗
In place	Currently not in place, previously recommended	Recommended for evaluation	Trending but not recommended at this time

Strategic Planning – Working Document



ORGANIZATIONAL INITIATIVES

CHANGES & UPDATES



1. Build incentives in favor of consumer driven plans

2.

3.

IN PROGRESS

1. Evaluation of alternative medical benefit plan designs
(See Exhibits Section, pages 34-35)

2. Evaluate changing the renewal plan year periods to
Jan – Dec from Jul – June for all lines of coverage

3.

PROJECTS



BENEFITS/HR GOALS 2022/2023

1. Jump start the wellbeing initiatives

2.

3.

SHORT TERM



BENEFITS/HR GOALS 2023/2024

1. Consider recalibration of the medical plan designs

2. Consider adding a non-embedded qualified HDHP

3. Evaluate UHC's Level2 Health Plan (diabetes focused)

4. Revisit UHC's Personal Health Support clinical program

LONG TERM



3 Year Strategic Plan

STRATEGY	2021/ 2022	2022/2023	2023/2024
POLICIES AND PROCEDURES	- Compliance checklist - Employee Benefits Trust	- Compliance checklist - UHC support with Consolidated Appropriations Act, No Surprises Act, Transparency requirements	Compliance checklist
PLAN DESIGN/ PROGRAMS	- UHC's Quit for Life and Real Appeal programs terminated. - Reviewed reference based pricing, 2nd opinion programs, condition specific programs for 2022/2023	Evaluated all benefits plans to continue competitiveness	- Evaluate all benefits plans to continue competitiveness, consumer driven incentives - Consider a non-embedded qualified HDHP
PRICING EFFICIENCY	- Reviewed unbundled health plan options - Negotiated medical/pharmacy renewal - Continued with pharmacy rebates	- Negotiated with UHC a hybrid pharmacy with rebates and admin credit - Marketed carved out stop loss and pharmacy, remained bundled with UHC	- Market carved out stop loss and pharmacy benefits - If available, consider TPA change to UMR to keep UHC network
POPULATION HEALTH STATUS/ WELLBEING PROGRAMMING	- EE survey – October 2021 - Continued education on consumer price transparency tools – <u>regulations effective 2021 on ACA's transparency requirements</u>	- Review Health Plan Performance Report - Review wellbeing inventory and identify gaps - Apply for WELCOAZ wellbeing program recognition awards and explore additional recognition award opportunities	- Review Health Plan Performance Report - Offer additional resources that address employee's top wellbeing interests - Apply for wellbeing program recognition awards annually - Conduct organizational assessment
CONTRIBUTION STRATEGY	- PPO no change in EE Only split of 85% Client / 15% EE. Dep tiers split change to 75% Client / 25%EE - HDHP no change in EE Only split of 100% Client / 0% EE. Dep tiers split change to 80% Client / 20%EE - Evaluated wellbeing premium incentive. Continued with \$30/month - No change in the Client HSA contributions	- PPO continued 2021/2022 split - HDHP continued 2021/2022 EE Only split. Changed dep tiers split to 77% Client / 23% EE - Evaluate Town's HSA contributions - Evaluated dental strategy - Evaluated wellbeing premium incentive. Continued with \$30/mth - No change in the Client HSA contributions	- Evaluated Town's medical contribution strategy - HDHP dep tiers scheduled to 75% Client / 25% EE - Evaluate Town's HSA contributions - Evaluate dental contribution strategy - Consider a contribution for vision benefit
COMMUNICATION/ OPEN ENROLLMENT	- Passive enrollment - Implemented communication technology & tracking tools	- Continued with a passive enrollment - Introduced additional resources to HR	Continue with a passive enrollment?
ANCILLARY LINES	CBIZ negotiated competitive renewals with carriers	- Upgraded dental High Plan – higher annual maximum and Basic coinsurance, with endodontic/periodontics covered as Basic services - Upgraded vision benefits to include the Insight network, and include a High Plan	Review life & disability benefits



Enhanced Focus

- **Personalization, Choice and Convenience**
 - Holistic and accessible wellbeing for all
 - Virtual health integrated with in-person care
 - Focus on Quality + Value over price
- **Psychosocial Safety**
 - Mental health & emotional wellbeing
 - Financial wellness
- **Emphasis on family-friendly benefits**
 - Back-up care resources
 - Concierge services
- **Culture and Engagement**
 - Increased Health Equity
 - Employee recognition platforms
 - Leadership trainings



Reduced Focus

- **Biometric screenings**
 - Increased focus on primary care visits
- **Onsite lunch and learns and onsite fitness classes**
 - Shift to virtual webinars and virtual fitness options
- **Health risk assessments**
 - Updated to include all aspects of wellbeing and culture
- **Wearable devices**
 - Move to mobile app-based programs

Emerging Trends - Mental Health & Wellbeing



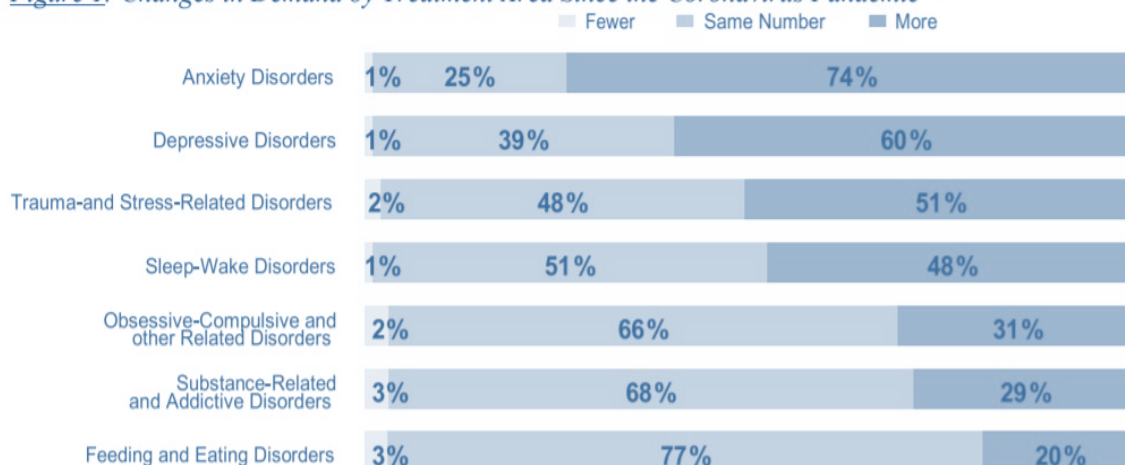
Mental Health and Wellbeing Awareness

- 83% of employees experience mental health issues, yet only 14% sought care
- 41% of companies have added mindfulness solutions (i.e. Calm, Headspace)
- 33% of companies have added third-party Mental Health solutions
- Company-wide “Mental Health” or “Wellbeing” days are growing in popularity (16% offering)

Mental Health and Wellbeing Strategies

- Balance the focus on mental and physical health
- Evaluate and establish workplace policies to establish mental health improvement
- Expand of mental health & emotional wellbeing solutions focused on quality & convenience.
- Evaluate supplemental mental health vendors
- Promote EAP offerings

Figure 1: Changes in Demand by Treatment Area Since the Coronavirus Pandemic^{viii}



CBIZ Engagement & Wellbeing

CBIZ Engagement & Wellbeing Consulting guides employers in creating thriving workplace cultures characterized by high employee wellbeing & engagement.

CBIZ Engagement and Wellbeing Key Differentiators

- ☐ Consulting best practices in wellbeing, engagement strategies, and workplace culture
- ☐ Framework for an effective wellbeing and engagement strategy and key drivers of wellbeing
- ☐ Expert consulting team and commitment to ethical wellness code and practice
- ☐ Extensive vendor knowledge (including wellbeing, EAP, culture, engagement and specialty vendors)
- ☐ High quality communications, engagement strategies & implementation of evidence-based wellbeing practices/programs
- ☐ Award winning clients in the US and Globally



CBIZ Engagement & Wellbeing Services & Resources	Currently in place	Recommended for evaluation
Wellbeing Communications: - Well Informed - Wellbeing Insights eMagazine & Self-Care Inspiration Calendar - Content for wellbeing communications	✓	
Wellbeing templates, sample notices/forms	✓	
Culture Network webinars & forum	✓	
Annual Strategic Plan	✓	
Guidance on Incentive Design	✓	
Wellbeing Inventory & Resource Optimization	✓	
Identify new wellbeing resources/services	✓	
Wellbeing Champion Development/Coaching	✓	
Vendor RFP & Implementation	✓	
Wellness award application guidance		2022-2023
Monitor Wellbeing Funds/Budget		2022-2023
Organizational assessment		2022-2023
Employee Wellbeing Interest survey		2023-2024

Wellbeing Action Plan



THRIVING WORKPLACE CULTURE GOALS:



1. Meaningful & inclusive programming
2. Target employee needs & interests
3. Maintain a supportive work environment conducive to a healthy lifestyle

EMPLOYEE'S PREFERRED WELLBEING AREAS OF FOCUS:



- Financial Wellbeing
- Stress Management
- Physical Activity
- Nutrition

Based on 2021 Employee Satisfaction Survey – 240 respondents

SHORT TERM GOALS | 2022-2023:



- Review wellbeing inventory and identify gaps
- Conduct organizational assessment
- Review Wellness Committee's purpose, leaders and members

LONG TERM GOALS | 2023 - 2024:



- Conduct employee wellbeing interest survey
- Evaluate wellbeing offerings
- Cultivate and empower Wellness Champions

WELLBEING VENDORS AND PARTNERS:

Alliance Work Partners ▪ CBIZ ▪ Onsite Clinic
UnitedHealthcare ▪ Wellness Council of Arizona

Communication and Education Checklist



STRATEGY & DEVELOPMENT

- ✓ Incorporate brand into benefits communication materials
- ✓ Population assessment and survey – Issued 10/2021



YEAR ROUND COMMUNICATION CAMPAIGN

- ☐ Calendar with deliverables*
- ☐ Messaging with sample emails, resources, and videos*
- ✓ Custom email header
- ✓ Monthly Wellbeing Insights Newsletter



OPEN ENROLLMENT SUPPORT

- ✓ Custom benefits guide
- ✓ Flyer and/or postcard with QR code
- ✓ Open enrollment communication strategy and timeline
- ✓ Virtual open enrollment presentation
- ✓ Resource Center that includes helpful links and resources regarding Open Enrollment
- ☐ Benefit administration management / third party vendor management*



MULTI-MEDIA SUPPORT

- ☐ Custom video creation*
- ✓ Interactive and trackable benefit guide software with FlippingBook
- ✓ Access to educational video library
- ✓ Live and recorded benefits webinars for open enrollment and new hires
- ☐ Enrollment technology options*



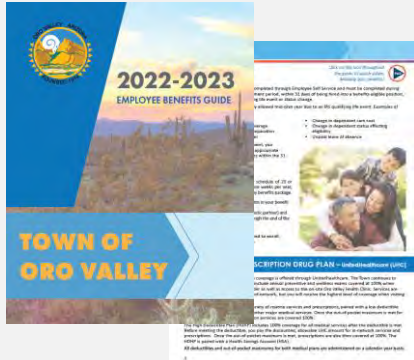
THIRD PARTY VENDOR MANAGEMENT

- ☐ Custom digital postcards, videos, and websites*
- ☐ Decision Support Resources*
- ☐ Enrollment and Benefit Administration Technology*

Open Enrollment Communications



Benefit Guide



- Custom to client branding
- 2020 changes & information about each line of coverage
- Educational videos / carrier resources linked throughout
- Sent electronically via FlippingBook

Custom Open Enrollment Announcement Video



- Custom video to announce open enrollment dates

Open Enrollment and HSA/HDHP Presentations



- Details changes & carrier information for each line of coverage
- Details how High Deductible Health Plans with Health Savings Accounts work
- Custom branding

Email Header & Content



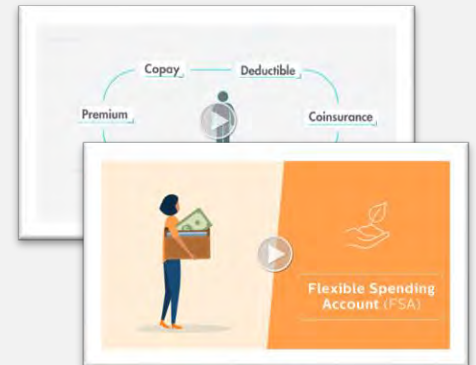
- Custom header for email communication that matches brand
- Access to sample email language

Resource Center



- Landing page with all OE resources
- Provide a one stop shop for all important links regarding OE
- Update buttons depending on time of OE and year (can change to be new hire applicable)

Educational Videos



- Access to educational videos that are linked in benefit guide

Resources provided for PY2022/2023

Compliance Reminders

Welfare Benefit Plan Reporting Reminders

Form	To Whom	Due Date
Form 5500	Department of Labor – Employee Benefit Security Administration (EBSA) http://www.efast.dol.gov	Within 7 months of end of plan year
Form M-1 (Form M-1 filers must also file Form 5500)	EBSA http://www.askebsa.dol.gov/me/wa/	March 1 of each year
Form W-2 Welfare benefit plan reporting includes: - Aggregate cost of health coverage (Box 12, using Code DD). Note, employers filing <250 Form W-2s per year remain exempt from reporting the aggregate cost of health coverage on the Form W-2 until future IRS guidance is issued. - HSA employer contributions plus amounts employees elect to contribute via an IRC §125 cafeteria plan (Box 12 - Code W) - Total amount of permitted benefits received under a qualified small employer health reimbursement arrangement (QSEHRA) (Box 12 - Code FF) - Disability income/sick pay benefits received by from third party payer - Amounts reimbursed via dependent care assistance program plus amounts exceeding maximum \$5,000 exclusion (include in Boxes 1, 3 and 5) - Cost of group term life insurance over \$50,000 (Table I rates) reported in Boxes 1, 3 and 5; and Box 12 - Code C - Additional Medicare tax withholding on earnings exceeding \$200,000 per calendar year (Box 6)	Internal Revenue Service (IRS) http://www.irs.gov/ About Form W-2, Wage and Tax Statement Internal Revenue Service (irs.gov)	January 31, 2023
Form 1094/1095		- By paper: February 28, 2023 - Efile: March 31, 2023
File Forms 1094/1095	IRS	
Furnish Form 1095; or, certain Form 1095-B reporting entities can utilize simplified posting method	Individuals listed in Forms 1094 and 1095	March 2, 2023
Form 720 for purposes of Patient Centered Outcome Research Institute (PCORI) fee	IRS	July 31 of each year
Medicare Part D Disclosure to CMS http://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html	Centers for Medicare & Medicaid Services (CMS)	Within 60 days of commencement of plan year

Compliance Reminders

Annual Welfare Benefit Plan Disclosure Reminders

<i>Document</i>	<i>To Whom</i>	<i>Timeframe</i>
Summary Annual Report (applicable to plans filing Form 5500)	Plan participants and certain beneficiaries	Annually - within 9 months after close of plan year
Annual Women's Health and Cancer Rights Act (WHCRA) Notice	Plan participants and certain beneficiaries	Annually
Medicaid/CHIP Premium Assistance Notice English (PDF or Word) Spanish (PDF or Word)	All employees eligible for employer-sponsored group health coverage who live in states providing premium assistance (see list of applicable states contained in model notice), without regard to where the employer is located, or where the health plan is situated	Annually
Medicare Part D Creditable or Non-Creditable Coverage Disclosure Notice	All Medicare-eligible individuals including current and former employees and Medicare-eligible dependents covered by plan or become eligible to enroll in plan	Annually
Summary of Benefits and Coverage (SBC) SBC template and related materials available from: ♦ DOL-EBSA ♦ HHS-CCIIO	All plan participants	Annual disclosure if related health plan contract renews on annual basis

Important Note: Two versions of these materials available:

- ♦ One set for plan years beginning on or after Jan. 1, 2021; or,
- ♦ One set for use on or after April 1, 2017

Compliance Reminders

Determining Applicable Covered Employer Status

<i>Law</i>	<i>Employee Threshold</i>
Affordable Care Act – Employer Shared Responsibility Penalty	50 full-time employees or full-time equivalent employees. Review number of employees at end of each calendar year for purposes of determining whether the shared responsibility requirements apply in following year
Age Discrimination in Employment Act (ADEA)	- State and local governments without regard to the number of employees; and - Private sector employers engaged in a business or industry affecting interstate commerce, who employ 20 or more employees on 20 or more calendar weeks in the current or preceding calendar year.
Americans with Disabilities Act (ADA)	15 or more employees on 20 or more calendar weeks in the current or preceding calendar year
Consolidated Omnibus Budget Reconciliation Act (COBRA)	20 or more common law employees on at least 50% of the business days in the preceding calendar year; includes full-time, part-time, and seasonal employees
Family and Medical Leave Act (FMLA)	Applies to public and private employers who employ 50 or more employees on each working day in 20 or more calendar weeks in current or preceding calendar year
Health Insurance Portability and Accountability Act (HIPAA)	Applies to all public and private employers employing at least two participants who are current employees
Medicare Secondary Payor Rules (MSP Rules)	<i>Medicare due to age:</i> 20 or more full or part-time employees on at least 20 calendar weeks in current or preceding calendar year <i>Medicare due to disability:</i> 100 full or part-time employees on at least 50% of regular business days in preceding calendar year <i>Medicare due to end-stage renal disease:</i> Applies without regard to employer size
Pregnancy Discrimination Act (PDA)	Public sector employers, and private sector employers engaged in a business or industry affecting interstate commerce, who employ 15 or more employees on each working day in at least 20 or more calendar weeks in the current or preceding calendar year. The law does not apply to the federal government, Indian tribes, or a department or agency of the District of Columbia.
Uniformed Services Employment and Reemployment Rights Act (USERRA)	Applies to all public and private employers, regardless of size

General

- [COVID-19 Resource Center](#)
- [Executive Insights](#)
- [Accelerated Recovery Resource Center](#)
- [Upcoming Webinars and Insights](#)
- [Managing Through COVID-19 & Beyond](#)
- [Biz Tips Employee Benefits Podcast](#)
- [On-Demand Webinars](#)

NEW WEBSITE – NOW LIVE

Check out the [new CBIZ website](#) that was launched in 2021 to make it easier to navigate to articles, resources, webinars and more.

Compliance

- [Compliance FAQs - Coronavirus](#)
- [At Issue Bookshelf Resource](#)
- [FAQ - Coronavirus: Impact on Benefits and Employment](#)
- [FAQ: COVID-19 Testing and Vaccines](#)
- [Regulatory & Legislative Update: What Employers Need to Know in 2021](#)

Employee Communication

- [Open Enrollment Success Guide](#)
- [Going Digital The Secret to Impactful Employee Benefits Communication - 3-Part Webcast Series](#)

Engagement & Wellbeing

- [Work-Life Integration Quick Tips Guide](#)
- [Navigating Remote Work & Leadership: Tips, Tricks & Advice](#)
- [3-Part On-Demand Webinar Series: Navigate Remote Work & Leadership During COVID-19](#)
- [Monthly Wellbeing Insights Newsletter](#)
- [Culture Network](#)
- [National Health Observances](#)

Cost Containment

- [From Fine Tuning to Transforming – Maximizing Your 2021 Employee Benefits Strategy](#)
- [State of Health Care Guide](#)
- [2022 Benchmarking Report](#)

Account Management Team



Oscar Diaz

Consultant and Team Lead

520.321.7511

Odiaz@cbiz.com

- Proactive client satisfaction level
- Identify client objectives
- Responsible for strategy development
- Contractual and renewal negotiations
- Marshall resources and client relationship management



Sonya Martinez

Senior Account Executive

520.321.7526

Smartinez@cbiz.com

- Responsible for overseeing the performance of the account management team
- Execute the strategy set by the employer and consulting team members
- Review financial and utilization data
- Assist in renewal and contractual negotiations
- Regulatory compliance consulting
- Assist in and monitor day-to-day client service issues



Suzan Martin

Account Manager

520.321.7521

SuzanMartin@CBIZ.com

- Oversee administration process
- Assist with communication strategy
- Regulatory compliance assistance
- Development of open enrollment material/employee communications
- Follow up with carrier on administrative issues
- Assist in resolving billing and claim issues



Anisa Karczynski

Engagement & Wellbeing Account Executive

520.321.7516

Akarczynski@cbiz.com

- Incentive design
- Gap analysis and culture assessment
- Vendor partnership
- Industry best practices
- Compliance with federal regulations governing corporate wellness programs



Angela Schlosser

Claims Advocate

520.321.7528

Aschlosser@cbiz.com

- Employee claims assistance
- Responsible for providing claim research for escalated claim issues
- Medicare Secondary payor issues

National Resources



ROBIN WIDDIS

Vice President of Operations

- Build strategic partnerships with clients and carriers to support customer needs
- Manage key service initiatives for clients including increased efficiencies, more expedient processes and overall better client experience



ERIN EASON

National Onsite Clinic Consultant

- Lead national practice dedicated to all components and steps of evaluating through implementing employer-sponsored health and wellbeing solutions for employers
- Provide general clinical consulting services to employers and organizations with existing clinic services, identifying opportunities for improvement



MIKE ZUCARELLI, PHARM.D

National Pharmacy Director

- Provide analysis and support for all Rx and PBM questions and projects
- Perform pharmacy plan evaluation, procurement, contract review, and implementation of pharmacy benefit management for self-insured plan sponsors
- Leverage PBM and carrier relationships to advocate vendor accountability and best practices on the client's behalf



KAREN MCLEESE, ESQ.

Vice President – Employee Benefits Regulatory Affairs

- In-house counsel for employee benefits and insurance laws
- Writes and distributes *For Your Benefit Book*, *At Issue*, *Benefit Beat* and *Health Reform Bulletin*
- Reviews and interprets federal and state laws and regulations impacting employee benefits



DAVE RUBADUE

National Director of Actuarial Services

- Mitigate actuarial costs
- Specializes in Premium Rate and Reserve Adequacy Development, Reserve and Contingency Fund Assessments
- Lead the National Actuarial Practice



ALEX LANNING

National Communications Director

- Lead national communication practice dedicated to enhancing employee communications
- Provide support in tandem with client service team to consult and strategize on communication goals



JULIE FULTON, CCWS

National Director of Wellbeing & Population Health Management

- Uses data to drive engagement strategies and the delivery of evidenced-based wellbeing solutions.
- Leads national practice focused on delivering custom multi-year wellbeing and engagement strategies.

UnitedHealthcare Reconciliation



July 1, 2021 to July 1, 2022

RECONCILIATION SUMMARY

Bank Account Adjustments:

Individual Stop Loss Adjustment:

Aggregate Stop Loss Adjustment:

Administration Fees and Premiums

	<u>Earned</u>		<u>Paid</u>		<u>Difference</u>
Total Monthly Administration Fees	\$	235,769	\$	235,769	\$ -
Shared Savings Plan	\$	18,046	\$	18,046	\$ -
Naviguard	\$	49,591	\$	49,591	\$ -
Total Administration Fees	\$	303,406	\$	303,406	\$ -
Individual Stop Loss Premium	\$	389,433	\$	389,433	\$ -
Aggregate Stop Loss Premium	\$	31,951	\$	31,951	\$ -
Total Stop Loss	\$	421,385	\$	421,385	\$ -
 Grand Total Fees and Premium	\$	724,790	\$	724,790	\$ -

Performance Guarantee Payout:

Total to be Credited to Customer	\$	-

Rx Discounts, Dispensing Fee, Rebate, Specialty Payout:

Total to be Credited to Customer	\$	(1,248)

Total Fees/Premium Due To UHC or (Customer)	\$	(1,248)

Total Adjustment To Customer's Bank Account	\$	-

Onsite Clinic Cost Avoidance Report

Sample Client

Onsite Clinic Cost Avoidance Report

Dates of Services: July 2021 - June 2022

*UnitedHealthcare - Market Average Reimbursement	HCS Reported Claims	HCS Reported Claimants	UHC Annualized Enrolled Employees	UHC Annualized Enrolled Members (EE/Sp/Ch)
	3964	647	297	707
\$114,928	\$28.99 Per Claim	\$177.63 Per Claimant	\$386.96 Per Employee	\$162.56 Per Member

Healthcare Solutions Center (HCS), LLC - Contract Fee	Claims	Claimants	Employees	Members (EE/Sp/Ch)
	3964	647	297	707
\$155,384	\$39.20 Per Claim	\$240.16 Per Month	\$523.18 Per Employee	\$219.78 Per Member

Clinic Savings - UHC v HCS				
	-\$40,456	-\$10.21	-\$62.53	-\$136.21
				-\$57.22

*UnitedHealthcare Covered amounts are based on all Sample Client processed/paid claims for the same services that were performed at in-network provider offices from July 1, 2021 – June 30, 2022 to provide a market average. Data did not include Healthcare Solutions Center, LLC. claims.

Estimated Cost of Lost Work	Total
Number of Patient Encounters	2014
HCS estimated time away from work	2 hours
Number of lost work hours	4028
**Average Hourly Rate	\$31.43
Total Productivity Cost	\$126,600

**Hourly rate calculated from 2022 data.



MEDICAL	UnitedHealthcare - Plan Year 2023/2024 Alternative							
	HSA 3000		HSA 1500		PPO 750		Level2 (Sample Plan Design)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (Individual / Family)	\$3,000/\$6,000	\$5,000/\$10,000	\$1,500/\$3,000	\$5,000/\$10,000	\$750/\$1,500	\$5,000/\$10,000	\$2,500/\$5,000	No Out of Network Coverage
Embedded / Non Embedded	Embedded		Non Embedded		Embedded		Embedded	
Coinsurance (on allowed amount)	100% - 0%	50% - 50%	100% - 0%	50% - 50%	80% -20%	50% - 50%	100% - 0%	
Max Out-of-Pocket (Individual / Family)	\$3,500/\$7,000	\$6,000/\$12,000	\$2,000/\$4,000	\$6,000/\$12,000	\$4,000/\$8,000	\$12,000/\$24,000	\$5,000/\$10,000	
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited	
Preventive Care								No Out of Network Coverage
Office Visits (PCP / Specialist)	Covered 100%	50% after deductible	Covered 100%	50% after deductible	Covered 100%	50% after deductible	Covered 100%	
Mammograms	Covered 100%	50% after deductible	Covered 100%	50% after deductible	Covered 100%	50% after deductible	Covered 100%	
Colonoscopies	Covered 100%	50% after deductible	Covered 100%	50% after deductible	Covered 100%	50% after deductible	Covered 100%	
Primary Care Office ♦ Non Preventive	100% after deductible	50% after deductible	100% after deductible	50% after deductible	\$25	50% after deductible	\$25 - Premium Designated \$50 - Non-Prem Designated	
Specialist Office ♦ Non Preventive	100% after deductible	50% after deductible	100% after deductible	50% after deductible	\$25 - Premium Designated \$50 - Non-Prem Designated	50% after deductible	\$25 - Premium Designated \$50 - Non-Prem Designated	
Behavioral Health/Substance Use	100% after deductible	50% after deductible	100% after deductible	50% after deductible	Inpatient - 50% after ded Outpatient - \$0	50% after deductible	Inpatient - \$450/visit after ded	
Rehabilitation	100% after deductible	50% after deductible	100% after deductible	50% after deductible	\$0	50% after deductible	\$50	
Chiropractic	100% after deductible	50% after deductible	100% after deductible	50% after deductible	\$15	50% after deductible	\$30	
Lab and X-Ray (Excluding Specialty Scans)							After Deductible	
Physician's Office	100% after deductible	50% after deductible	100% after deductible	50% after deductible	Lab \$0 / X-Ray \$25	50% after deductible	\$50	
Freestanding Facility	100% after deductible	50% after deductible	100% after deductible	50% after deductible	Lab \$0 / X-Ray \$25	50% after deductible	\$50	
Outpatient Hospital	100% after deductible	50% after deductible	100% after deductible	50% after deductible	Lab \$0 / X-Ray \$25	50% after deductible	\$100	
Specialty/Complex Scans	100% after deductible	50% after deductible	100% after deductible	50% after deductible	50% after deductible	50% after deductible	After Deductible Freestanding Facility - \$250 Hospital - \$500	
Inpatient Hospitalization	100% after deductible	50% after deductible	100% after deductible	50% after deductible	50% after deductible	50% after deductible	After Deductible \$450/per admit	
Emergency Room	100% after deductible		100% after deductible		\$250		After Deductible \$300	
Urgent Care	100% after deductible	50% after deductible	100% after deductible	50% after deductible	\$40	50% after deductible	\$75	
Convenience Care	100% after deductible	50% after deductible	100% after deductible	50% after deductible	\$25	50% after deductible	\$25	
Telemedicine	100% after deductible	50% after deductible	100% after deductible	50% after deductible	\$0	50% after deductible	\$0	
Prescription Drugs								
Retail	\$10/\$30/\$50 after ded	50% after deductible	\$10/\$30/\$50 after ded	50% after deductible	\$10/\$30/\$60	Copay + cost difference	\$8/\$40/\$50%	
Mail Order	\$20/\$60/\$100 after ded	Not Covered	\$20/\$60/\$100 after ded	Not Covered	\$20/\$60/\$120	Not Covered	\$20/\$100/50%	

Refer to UHC's Level2 collateral regarding the Enhanced Benefits included in this plan design.

Sample Client
2023/2024 Plan Design Impact v1

	<u>HDHP 2800</u>		<u>PPO 750</u>	
<u>Increments/Decrements</u>				
Option 1	Dec. Ded T1 - \$2,800/\$5,600 to \$3,000/\$6,000		Dec. Ded T2 - \$1,000/\$2,000 to \$5,000/\$10,000	
	-1.2%	(\$33,152)	-2.9%	(\$81,240)
Option 2	Dec. Ded T2 - \$4,500/\$9,000 to \$5,000/\$10,000		Dec. OOPM T1 - \$2,500/\$5,000 to \$4,000/\$8,000	
	-0.4%	(\$11,767)	-1.6%	(\$46,046)
Option 3	Dec. Coin. - 100%/80% to 100%/50%		Dec. OOPM T2 - \$5,000/\$10,000 to \$12,000/\$24,000	
	-0.1%	(\$1,993)	-1.6%	(\$43,760)
Option 4	Dec. OOPM - T2 - \$5,500/\$11,000 to \$6,000/\$12,000			
	-0.2%	(\$5,103)		
Option 5	Above Opts 1-4 Combined		Above Opts 1-3 Combined	
	-1.9%	(\$50,527)	-6.4%	(\$179,443)
Option 6	Inc. HDHP 1500 - Non-Embedded - Ded IN \$1,500/\$3,000; OON \$5,000/\$10,000; Coin. 100%/50%: OOPM IN \$2,000/\$4,000; OON \$6,000/\$12,000			
	7.5%	\$209,719		

Caveats:

This method of pricing the variances is an industry standard however, it looks at each plan independently, does not take into consideration the affects of migration, or the affects of different plan design combinations.

The sum of each plan design change will not equal the combined plan design changes due to induced/reduced demand and counteractive changes.

Medical Benefit Summary – 2022/2023

	UnitedHealthcare			
	HSA 2800		PPO 750	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (Individual / Family)	\$2,800/\$5,600	\$4,500/\$9,000	\$750/\$1,500	\$1,000/\$2,000
Coinsurance (on allowed amount)	100% - 0%	80% - 20%	80% - 20%	50% - 50%
Max Out-of-Pocket (Individual / Family)	\$3,500/\$7,000	\$5,500/\$11,000	\$2,500/\$5,000	\$5,000/\$10,000
Includes Deductible?	Yes	Yes	Yes	Yes
Includes Copayments?	Yes	N/A	Yes	Yes
Lifetime Maximum	Unlimited		Unlimited	
Preventive Care				
Office Visits (PCP / Specialist)	Covered 100%	20% after deductible	Covered 100%	50% after deductible
Mammograms	Covered 100%	20% after deductible	Covered 100%	50% after deductible
Colonoscopies	Covered 100%	20% after deductible	Covered 100%	50% after deductible
Primary Care Office ♦ Non Preventive	100% after deductible	20% after deductible	\$25	50% after deductible
Specialist Office ♦ Non Preventive	100% after deductible	20% after deductible	\$25 – Premium Designated \$50 – Non-Prem Designated	50% after deductible
Behavioral Health/Substance Use	100% after deductible	20% after deductible	Inpatient - 20% after ded Outpatient - \$0	50% after deductible
Rehabilitations Services	100% after deductible	20% after deductible	\$0	50% after deductible
Chiropractic	100% after deductible	20% after deductible	\$15	50% after deductible
Lab and X-Ray (Excluding Specialty Scans)				
Physician's Office	100% after deductible	20% after deductible	Lab \$0 / X-Ray \$25	50% after deductible
Freestanding Facility	100% after deductible	20% after deductible	Lab \$0 / X-Ray \$25	50% after deductible
Outpatient Hospital	100% after deductible	20% after deductible	Lab \$0 / X-Ray \$25	50% after deductible
Specialty/Complex Scans	100% after deductible	20% after deductible	20% after deductible	50% after deductible
Inpatient Hospitalization	100% after deductible	20% after deductible	20% after deductible	50% after deductible
Emergency Room	100% after deductible		\$250	
Urgent Care	100% after deductible	20% after deductible	\$40	50% after deductible
Convenience Care	100% after deductible	20% after deductible	\$25	50% after deductible
Telemedicine	100% after deductible	20% after deductible	\$0	50% after deductible
Prescription Drugs				
Retail	\$10/\$30/\$50 after ded	20% after deductible	\$10/\$30/\$60	Copay + cost difference
Mail Order	\$20/\$60/\$100 after ded	Not Covered	\$20/\$60/\$120	Not Covered
RATES				
Employee Only	\$379.34		\$440.39	
Employee + Spouse	\$948.35		\$1,167.03	
Employee + Child(ren)	\$739.71		\$858.76	
Employee + Family	\$1,392.18		\$1,761.56	

Contribution strategy:

- No change in Funding Rates/Total Cost tiers from 2021/2022
- PPO - no change in contribution split of Employee Only tier of 85% Client / 15% Employee
- PPO - no change in contribution split for dependent tiers of 75% Client / 25% Employee
- HDHP - no change in contribution split of Employee Only tier of 100% Client / 0% Employee
- HDHP - Change Employee contribution for dependent tiers to 77% Client / 23% Employee from 80% Client / 20% Employee Strategy goal to get to 75% Client / 25% Employee
- "Know Your Numbers" Participation (Non-participation would add \$15 per pay period to employee premium)
- No premium holiday(s)
- No change to HSA contributions from 2021/2022
- Aggregate employee cost share increase \$16,705.68

Dental Benefit Summary – 2022/2023

	Delta Dental			
	Low		High	
	In Network	Out-of-Network	In Network	Out-of-Network
Annual Maximum	\$1,750	\$1,000	\$2,000	\$1,000
Deductible (Individual / Family)	\$50/\$150	\$100/\$300	\$50/\$150	\$50/\$150
Waived for Preventive	Yes	Yes	Yes	Yes
Preventive	100%	60%	100%	80%
Basic	80% Oral Surg	40% Oral Surg	100% Oral Surg, Endo, Perio	80% Oral Surg, Endo, Perio
Major	50% Endo & Perio	10% Endo & Perio	50%	40%
Orthodontia (Child Only)	No Deductible Covered at 50% to a lifetime max of \$1,000	No Deductible Covered at 20% to a lifetime max of \$500	No Deductible Covered at 50% to a lifetime max of \$1,000	
Annual Open Enrollment	Yes		Yes	
Rate Guarantee	Through 6/30/2023			
RATES				
Employee Only	\$26.20		\$33.78	
Employee + Spouse	\$53.71		\$69.25	
Employee + Child(ren)	\$61.56		\$79.40	
Employee + Family	\$86.47		\$111.52	

Plan designs:

Low Plan – no changes

High Plan includes the following upgrades from 2021/2022:

- Increased annual maximum of \$2,000/per enrolled member from \$1,750/per enrolled member
- Increased Basic coinsurance of 100% in network / 80% out of network from 80% in network / 60% out of network
- Endodontics and periodontics moved to Basic services from Major services

Rates & contribution strategy:

- 1-year rate guarantee
- Rates updated to include the selected High Plan option with enhanced benefits
- Low Plan - Client covers 100% of EE Only and 75% of Dependent cost
- High Plan - Client covers 76% of EE Only and 60% of Dependent cost
- Aggregate employee cost share increase \$3,257.33
- Aggregate Client cost share increase \$6,909.67

Vision Benefit Summary – 2022/2023

	EyeMed Vision	
	Low Plan	High Plan
Description of Coverage	In Network	In Network
Exam with dilation as necessary	\$10 copay	\$10 copay
Examination Frequency	Every 12 months	Lenses (in lieu of contacts) every 12 months Frames every 12 months Contacts (in lieu of lenses) every 12 months
Frames	\$25 copay, \$120 allowance, 20% off balance	\$0 copay, \$160 allowance, 20% off balance
Lenses Coverage		
Single, Bifocal, Trifocal	\$25 copay	\$25 copay
Progressive	Standard - \$90 copay Premium Tier 1 - \$110 copay Premium Tier 2 - \$120 copay Premium Tier 3 - \$135 copay Premium Tier 4 - \$90 copay, 20% off retail price less \$120 allowance	Standard - \$90 copay Premium Tier 1 - \$110 copay Premium Tier 2 - \$120 copay Premium Tier 3 - \$135 copay Premium Tier 4 - \$90 copay, 20% off retail price less \$120 allowance
Lens Options	Anti Reflective Coating \$45 - \$68, Polycarbonate/Standard \$40, Scratch Coating \$15, Tint \$15, UV Treatment \$15	Anti Reflective Coating \$45 - \$68, Polycarbonate/Standard \$40, Scratch Coating \$15, Tint \$15, UV Treatment \$15
Contacts in lieu of eyeglasses		
Fit & Follow-up	Standard - member pays up to \$40 Premium - 10% of retail price	Standard - up to \$40 copay Premium - 10% of retail price
Lenses Coverage	Conventional - \$0 copay, \$135 allowance (applies to materials only), 15% off balance Disposable - \$0 copay, \$135 allowance (applies to materials only), member pays any balance over \$135 Medically Necessary - \$0 copay, covered in full	Conventional - \$0 copay, \$160 allowance (applies to materials only), 15% off balance Disposable - \$0 copay, \$160 allowance (applies to materials only), member pays any balance over \$160 Medically Necessary - \$0 copay, covered in full
Laser Vision Correction - LASIK & PRK	15% off retail price or 5% off promotional pricing	15% off retail price or 5% off promotional pricing
Materials Frequency	Lenses (in lieu of contacts) every 12 months Frames every 24 months Contacts (in lieu of lenses) every 12 months	Lenses (in lieu of contacts) every 12 months Frames every 12 months Contacts (in lieu of lenses) every 12 months
Network	Insight	
Rate Guarantee	Through 6/30/2026	
RATES		
Employee Only	\$5.87	\$9.78
Employee + One	\$11.16	\$18.58
Employee + Family	\$16.40	\$27.31

Plan designs:

Network change to EyeMed's Insight Network

Low Plan

- Better tier pricing for progressive lenses

High Plan

- Added as an option
- Frame frequency every 12 months
- Higher allowances for frames and contacts

Rates & contribution strategy:

- 4-year rate guarantee
- Slight increase on Low Plan rates
- Employee pays 100% of the premium regardless of tier enrollment

Life Benefit Summary – 2022/2023

GROUP LIFE and ACCIDENTAL DEATH & DISMEMBERMENT	Mutual of Omaha
Benefit Amount	1x annual salary up to \$200,000 Minimum \$25,000
Reduction Schedule	65% at age 65; 50% at age 70 of original amount
Waiver of Premium	Yes
Accelerated Benefit	80% of benefit
Conversion	Yes
Rate Guarantee	Through 6/30/2023
RATES per \$1,000	
Life	\$0.110
AD&D	\$0.020
Total	\$0.130

SUPPLEMENTAL LIFE and ACCIDENTAL DEATH & DISMEMBERMENT	Mutual of Omaha
Employee	\$500K in \$10K increments (no more than 5x annual salary)
Reduction Schedule	65% at age 65; 50% at age 70 of original amount
Guarantee Issue	5x annual salary, up to \$100k
Spouse	100% of Employee benefit to \$250K in \$5K increments
Guarantee Issue	100% of employee benefit, up to \$30k
Children	14 days & older - \$5K - \$10K in \$5K increments
Rate Guarantee	Through 6/30/2023
MONTHLY RATES per \$1,000	Employee & Spouse
Ages	
<29	\$0.070
45-49	\$0.240
50-54	\$0.400
55-59	\$0.630
60-64	\$0.980
65-69	\$1.760
70+	\$3.140
Dependent Life per \$1,000	\$0.09
Accidental Death & Dismemberment per \$1,000	Employee/Spouse/Child \$0.030

Disability Benefit Summary – 2022/2023

GROUP SHORT TERM DISABILITY	Mutual of Omaha
Benefit Duration	13 weeks
Benefit Percentage	66.67%
Maximum Weekly Benefit	\$2,000
Elimination Period	
Accident	90 days
Sickness	90 days
Pre-Existing Conditions	None
FICA Employer Contribution/W-2 Reporting	Included
Rate Guarantee	Through 6/30/2023
RATES	
Per \$10 of <u>benefit</u>	\$0.050

GROUP LONG TERM DISABILITY	Mutual of Omaha
Elimination Period	180 days
Benefit Percentage	66.67%
Maximum Monthly Benefit	\$6,700
Minimum Monthly Benefit	Greater of 10% or \$100
Own Occupation Benefit	24 months
Maximum Benefit Period	Social Security Normal Retirement Age
Mental/Nervous Benefit	24 months
Pre-Existing Conditions	3 months prior/12 months insured
Survivor Benefit	3 times last monthly gross benefit
FICA Employer Contribution/W-2 Reporting	Included
Rate Guarantee	Through 6/30/2023
RATES	
Per \$100 of <u>covered payroll</u>	\$0.290

Service Timeline

SAMPLE CLIENT SERVICE TIMELINE		
QUARTER	ACTIVITIES / DELIVERABLES	RESPONSIBLE
Q1 <i>July August September</i>	- Post renewal / carrier transition tasks - Deliver year end claims analysis - Carrier document delivery - Document review - Monthly: - Monthly medical and pharmacy financial reporting - Quarterly Strategic Health Plan reporting - Regulatory updates “Benefit Beat” and Healthcare Reform Bulletins - Wellbeing Insights Newsletters	CBIZ/Client/Carriers CBIZ Carrier(s) CBIZ CBIZ
Q2 <i>October November December</i>	- CBIZ and UHC 2021-2022 Annual Performance Reviews - Compliance checklist - Prerenewal/Strategic meeting - Monthly: - Monthly medical and pharmacy financial reporting - Quarterly Strategic Health Plan reporting - Regulatory updates “Benefit Beat” and Healthcare Reform Bulletins - Wellbeing Insights Newsletters	CBIZ/Client/UHC Client CBIZ/Client CBIZ
Q3 <i>January February March</i>	- Renewal planning (projections, communications, technology) - Develop & issue RFP (if applicable) - Carrier renewal delivery - Renewal presentation / RFP results - Plan open enrollment/communication strategy (meetings, videos, Brainshark, virtual resources, etc.) - Monthly: - Monthly medical and pharmacy financial reporting - Quarterly Strategic Health Plan reporting - Regulatory updates “Benefit Beat” and Healthcare Reform Bulletins - Wellbeing Insights Newsletters	CBIZ/Client CBIZ CBIZ CBIZ CBIZ/Client CBIZ
Q4 <i>April May June</i>	- Renewal decisions - Contribution strategies and calculations - Open enrollment/communication strategy implementation - Open enrollment - Enrollment elections finalized with carriers - Implementation and renewal document review - Monthly: - Monthly medical and pharmacy financial reporting - Quarterly Strategic Health Plan reporting - Regulatory updates “Benefit Beat” and Healthcare Reform Bulletins - Wellbeing Insights Newsletters	CBIZ/Client CBIZ/Client CBIZ/Client CBIZ CBIZ/Client/Carriers CBIZ/Carriers CBIZ
As Needed/ Ongoing	- Client service support - Claim advocacy support - Billing & eligibility assistance - Compliance & HR resources	CBIZ

Historical Renewals - Medical

Renewal Date	Summary
July 1, 2020	- Final negotiated renewal released with an overall 2.6% increase / \$100,214 maximum liability (fixed + claims) increase. Total annual maximum liability \$3,889,760 - Administration Fee: rate pass and included a pharmacy credit of \$32.18 PEPM - Decision to replace pharmacy credit with Fixed Rebates. - Administration Fee updated to \$64.26 PEPM. - Stop Loss Premiums: 9.3% increase / \$30,648 additional cost - Experience Refund Endorsement elected - Maximum Claim Projection: 1.2% decrease / \$40,875 cost reduction - CBIZ's Funding Projection resulted in a 3.4% decrease under the 2019 -2020 implemented rates. - Client moved forward with a premium funding rate pass. - Approved Town's Know Your Numbers contribution share with employees: - PPO – EE Only – 85% Client / 15% Employee - EE + Dependent Tiers – 77% Client / 23% Employee - HDHP – EE Only – 100% Client / 0% Employee - EE + Dependent Tiers – 85% Client / 15% Employee - Know Your Numbers incentive continued. An employee is eligible for a \$30 monthly premium credit for their participation. - Benefit plan changes: - Enhanced Personal Health Support 3.0 was included with no additional cost and replaced the Standard Care Coordination program - Decreased the Maximum Non-Network Reimbursement to 30% from 50% - PPO – None - HDHP – Deductible increase to \$2,800/\$5,600 to continue IRS embedded status. - Added the IRS' expanded list of preventive care services for QHDHP members
July 1, 2019	- Final negotiated renewal released with an overall 15.4% increase / \$526,754 maximum liability (fixed + claims) increase. Total annual maximum liability \$3,956,914 - Administration Fee: 6.8% decrease / \$14,980 in savings and included a pharmacy credit of \$30.80 PEPM - Stop Loss Premiums: 5.9% increase / \$19,167 additional cost - Maximum Claim Projection: 17.6% increase / \$522,525 additional cost - CBIZ's initial Funding Projection resulted in a 5.41% decrease under the 2018 -2019 implemented rates. The Client requested a Funding Projection that equated to a 5% increase in order to continue building reserves. To accommodate this request, a Reserve Factor of \$102.47 PEPM was included. - Approved Client contribution share with employees: - PPO – EE Only – 85% Client / 15% Employee - EE + Dependent Tiers – 77% Client / 23% Employee - HDHP – EE Only – 91% Client / 9 Employee - EE + Dependent Tiers – 85% Client / 15% Employee - Know Your Numbers incentive continued. An employee is eligible for a \$30 monthly premium credit, if the employee participates in the program. - Benefit plan changes: - PPO – emergency room copay increase to \$250/visit, chiropractic copay increase to \$15/visit, non preventive lab copay decrease to \$0 - HDHP - None

Historical Renewals - Medical



Renewal Date	Summary
July 1, 2018	- At the time of the renewal, the plan's utilization was below what was expected at the time the 2017-2018 renewal was negotiated and finalized. With this in mind, the renewal process included an evaluation of carving out stop loss and the pharmacy benefit manager. Due to time commitments needed to implement an unbundled program, the decision was tabled for the 2019-2020 plan year. - After renewal negotiations with UHC, the medical benefit contract continued with UHC. UHC initially released a .9% / \$5,336 administration and stop loss premium renewal increase. After negotiations, modifications to UHC's administration services fee and stop loss contract were made, the renewal was accepted with a -18.9% / -\$108,942 decrease. - The aggregate corridor remained at 125% with a contract basis of Paid/12 with terminal liability. The individual stop loss deductible was increased to \$150K from \$125K. The overall Expected annual cost (fixed + claims) decrease was -19.3% / -\$694,994. - CBIZ worked closely with the Client to develop funding rates and contribution levels. The final rates adjusted the tier ratios and plan value relativities in order to be actuarially correct. An 85/15 cost share model was continued. The employee premium differential continued for participation in the Know Your Numbers. - Plan changes included: - High Deductible Plan – increased deductible to \$2,700/\$5,400 - PPO Plan – changed Specialist copay to \$25 Premium Designated and \$50 Non-Premium Designated
July 1, 2017	- After extensive renewal negotiations with UHC and the market, the medical benefit contract continued with UHC. Bundled and unbundled self-funding arrangements were evaluated. The evaluations included placing the stop loss and pharmacy benefit manager as contracts that are carved-out of the third party administration services. - Due to concerns with the Town's high utilization and large claimants, the market had challenges in issuing competitive options. UHC would also impose additional fees in order to integrate with the carved out carriers. The UHC run-out administration and claim costs were included in the evaluation. - The aggregate corridor remained at 125% with a contract basis of Paid/12 with terminal liability. The UHC renewal included the laser of one large claimant. The overall Expected annual cost (fixed + claims) increase was 17.4% / \$510,039. - The Client moved forward in developing the funding rates and contribution levels. The 85/15 cost share model was continued. The employee premium differential was increased to \$30 per month for the participation in Know Your Numbers. - Plan changes included: - High Deductible Plan – None - PPO Plan – increased deductible to \$750/1,500, increased physician copays to \$25/\$50, increased emergency room copay to \$150, decreased virtual visit/rehabilitation/outpatient mental health & substance abuse copay to \$0.

Historical Renewals – Dental & Vision

Renewal Date	Summary of Dental Renewals
July 1, 2020	- In rate guarantee that expires June 30, 2021. - Benefits continued with Delta Dental.
July 1, 2019	- MetLife rate guarantee expired June 30, 2019. - Renewal released with a 45% rate increase and a 1 year rate guarantee. Negotiated renewal to a 36% rate increase and a 1 year rate guarantee with a 6% rate cap for the 2020/2021 renewal. - Marketing of the benefits, fully insured and self funded, was requested by the Client. - Decision to change to Delta Dental with a fully insured policy, 29.7% increase, and a 2 year rate guarantee.
July 1, 2018	Benefits continued with MetLife under the 2nd year of the 2-year rate guarantee.
July 1, 2017	- Due to a continuing increase in cost for the dental claims, the Client requested fully insured proposals which were evaluated along with self-funded proposals. - After renewal negotiations with Principal and the market, the dental benefit contract was awarded to MetLife for a 2-year rate guarantee under a fully insured policy. The estimated annual savings was \$40,400. The Client continued with a dual option benefit offering. MetLife's offer included enhancements to both dental plans, including an increase to the annual maximum of \$1,750 from \$1,500.

Renewal Date	Summary of Vision Renewals
July 1, 2020	- In rate guarantee that expires June 30, 2022. - Benefits continued with EyeMed.
July 1, 2019	- In rate guarantee that expires June 30, 2022. - Benefits continued with EyeMed.
July 1, 2018	The EyeMed renewal was accepted with a rate pass and a 4-year rate guarantee.
July 1, 2017	Benefits continued with EyeMed under the 4th year of the 4-year rate guarantee.

Historical Renewals – Other Benefits

Renewal Date	Summary of Life / AD&D / Disability Renewals
July 1, 2020	- All life benefits continued with Mutual of Omaha. Renewal released with a 1-year rate pass through June 30, 2021. - Short term disability renewal received and accepted with a rate pass and a 2-year rate guarantee through June 30, 2021. - Long term disability continued with Mutual of Omaha under the 3rd year of the 3-year rate guarantee through June 30, 2020.
July 1, 2019	- All life benefits continued with Mutual of Omaha under the 3rd year of the 3-year rate guarantee through June 30, 2020. - Short term disability renewal received and accepted with a rate pass and a 2-year rate guarantee through June 30, 2021. - Long term disability continued with Mutual of Omaha under the 3rd year of the 3-year rate guarantee through June 30, 2020.
July 1, 2018	- All life benefits continued with Mutual of Omaha under the 2nd year of the 3-year rate guarantee. - Short term disability continued with Mutual of Omaha under the 2nd year of the 2-year rate guarantee. - Long term disability continued with Mutual of Omaha under the 2nd year of the 3-year rate guarantee.
July 1, 2017	After renewal negotiations with Principal and the market, the life and disability contract was awarded to Mutual of Omaha. The life and long term disability benefits include a 3-year rate guarantee. The short term disability included 2-year rate guarantee. The estimated annual savings was \$9,100.

Renewal Date	Additional Benefit Lines
Employee Assistance Program	- In rate guarantee that expires June 30, 2023. Benefits continued with Jorgensen Brooks Group. - Jorgensen Brooks Group 2019/2020 renewal released and accepted with a rate pass and a 3-year rate guarantee. 2018/2019 benefits continued with Jorgensen Brooks under the 3rd year of the 3-year rate guarantee.
Worksite Voluntary Benefits	Benefits continued with Colonial.
Legal Assistance / Identity Theft	Benefits continued with LegalShield.
Flexible Benefits Administration	Benefits continued with CBIZ Flex.
COBRA Administration	Benefits continued with CBIZ COBRA.



SECTION 3

WELLBEING SERVICES COMMUNICATIONS SAMPLES



Wellbeing

Insights

Living a Better, More Vibrant Life



Breaking Barriers to Otherness with Active Listening

When was the last time you felt heard? That is, the person you were speaking with was completely engaged in your conversation and deeply interested in understanding you. It's a wonderful gift to feel heard. Perhaps that's due in part to how rare it is. We all know the value of this feeling, yet many of us fail to cultivate the skills needed to give our presence to others.

The skill of listening is not outwardly valued as highly as the skill of speaking eloquently in our society. However, it's a powerful tool to help close the divide between people, particularly in an atmosphere where societal and political tensions are high.

Many people turn to social media for a sense of connectedness. While these platforms provide a way to post our thoughts, ideas and experiences, they're really more about sharing and less about listening. This can create a virtual tinderbox for perpetuating "otherness." We tend to scroll through our feed and divide people into "us" and "them," which can cause rifts to deepen based on assuming instead of understanding. Imagine if we approached others with curiosity and respect. It's possible to narrow the space between "us" and "them" with a bit of active listening, putting the humanity that we share above the opinions that we may not.

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September

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Looking for ways to boost your self-care routine?

Click [here](#) for your daily inspiration!



Breaking Barriers to Otherness with Active Listening

Continued from page 1

If you're tired of feeling at war with others or simply frustrated over how they could believe/promote something, here are some tips to help you listen, connect and coexist more peacefully:

Set an intention to understand. Set a rule for yourself that you will not interrupt, defend or attempt to persuade. Aim to understand and not to debate or “win” the conversation. If you're passionate about a certain issue, it's natural to want to educate and persuade others or defend your ideals. You may also feel that listening to the other perspective is a weakness or backing down. Consider that one of the most courageous things you can do is be quiet, listen and absorb. You won't agree with everything that's said, and that's ok. Remember, your goal isn't to come to an agreement, it's simply to acknowledge the other person and provide them with an opportunity to feel heard.

Mindful Minute

Active listening requires that you truly hear the other person and notice when you're getting lost in your own thoughts. Similar to a basic mindfulness practice, it's all about staying present in the moment. If you find yourself drifting in thought, keep coming back to genuine listening. Once you're in the moment, you can work on going deeper in conversation. Listening involves paying attention to both what the other person is saying and what they're trying to communicate beyond words. **The HEAR practice can help you cultivate deeper listening skills.**

Halt — Halt whatever you're doing and offer your full attention.

Enjoy — Enjoy a breath as you choose to receive whatever is being communicated to you — wanted or unwanted.

Ask — Ask yourself if you understand what's being communicated and, if you don't, ask for clarification. Instead of making assumptions, bring openness and curiosity to the interaction.

Reflect — Reflect back to them what you heard. This conveys that you were really listening.

Adapted from mindful.org

“If they **respect you**, respect them. If they disrespect you, **still respect them**. Do not allow the actions of others to decrease your good manners, because **you represent yourself**, not others.”

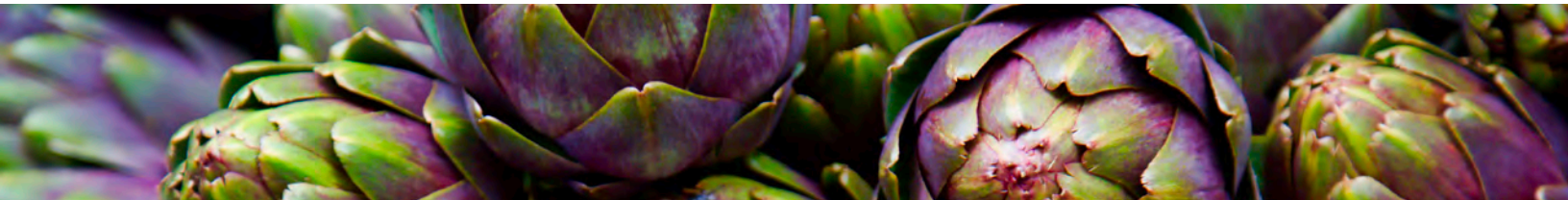
— MOHAMED ZEYARA

Keep a student mindset. Focus on being interested versus being perceived as interesting or an expert. Go into the conversation with the attitude that you can learn something from everyone. Be selfish in pulling every piece of insight you can from the other person to find what you can learn from them. Again, that doesn't mean you have to buy into their viewpoints, simply that you can gain new insight from their experiences. Refer to the Mindful Minute segment for an exercise in basic active listening.

Set assumptions aside. When you're speaking with someone you might consider an “other,” it means you already have some assumptions or bias. Avoid the urge to ascribe viewpoints or put words in the other person's mouth. This means no defensive or targeting questions; simply stay curious. If strong emotions are unavoidable as the result of opposing viewpoints, consider acknowledging that you're both passionate or have been shaped by difficult life experiences, or respectfully suggest taking a break from the conversation to reflect, research and gain some perspective.

Extend empathy. Perhaps the strongest tool for understanding someone is to put yourself in their shoes, trying to imagine the world as they've experienced it. That is, give them a piece of your heart, not a piece of your mind. Keep in mind that their message may extend beyond their actual words. Try to visually identify their emotions, body language and sentiments.

W.A.I.T before speaking. When you feel tempted to interject, ask yourself “Why Am I Talking?” If the answer is to present an argument or belittle the other person's viewpoint, reconsider. Instead, ask more clarifying questions. If the answer is to provide a “one-upper” story of your own, reconsider. Ask them more questions about their experience versus redirecting the conversation back to you.



On the Menu

All About Artichokes

Artichokes are an interesting vegetable with a long history and reputation for having myriad health benefits. Derived from the thistle family, artichokes first appeared in the Mediterranean and were enjoyed by ancient Greeks and Romans. They're reportedly one of the oldest foods known to humans and have been held in high regard for centuries. In fact, during the 16th century, eating an artichoke was reserved only for men because they were considered a strong aphrodisiac and not suitable for women.

Cultivation of the vegetable spread throughout the western hemisphere and eventually reached the U.S. through California. Today, California remains the main producer of globe artichokes in the U.S.

Artichokes have been sought after for centuries for their proposed medicinal properties. Today, we know they have high nutritional value. Studies have shown that artichokes can provide many health benefits, including:

- High levels of dietary fiber, which can help control constipation and decrease "bad" cholesterol
- Chemical compounds cynarin and sesquiterpene-lactones, which are known to maintain healthy blood cholesterol levels
- Large amount of vitamin C, which helps develop resistance against infections and free radicals in the body
- Great source of vitamin K, which plays a vital role in bone and brain health
- Rich source of B-complex vitamins, which are essential for optimal cell function
- Excellent source of folic acid, which is especially important during early pregnancy in helping to prevent neural tube defects in newborn babies

Keep It Fresh

Artichokes are a popular fall/winter vegetable but can be found in grocery stores year-round. Choose fresh artichokes that feel heavy and don't exhibit any cuts or bruises. The leaves of the artichoke should be compact and dark green. They're best used while fresh but can be kept well in the refrigerator in a sealed plastic bag up to one week.

Quinoa-Stuffed Artichokes

Ingredients:

- 4 large artichokes
- 1 lemon
- 1 cup quinoa, cooked per package instructions
- ½ cup grated Parmesan cheese
- 2 Tbsp. freshly chopped mint
- 2 Tbsp. freshly chopped parsley

Directions:

- Fill a large bowl with water and juice of the lemon and stir well. Cut stems of the artichokes so they sit flat and peel stems with a paring knife. Carefully cut off the top third portion of the artichoke and use scissors to clip off the sharp leaf points. Put artichokes in bowl with lemon and water.
- Bring a large pot of water to boil (water depth of 1-2"). Once boiling, arrange trimmed artichokes, bottoms up, in a single layer. Cover pot, reduce heat to medium-low and steam until tender, about 20-40 minutes. Artichokes are ready when the leaves pull out easily and the base can be pierced with a knife. Drain well.
- Combine cooked quinoa, Parmesan, mint and parsley in a bowl.
- Preheat oven to 400°F. Remove the center leaves from each artichoke and scoop out and discard the fuzzy center. Place artichokes stem side down in a baking pan and stuff with quinoa mixture. Bake 20 minutes or until heated through.

Nutrition Info

Per Serving (1 artichoke)

Calories	370
Carbohydrates	66g
Sugar	4g
Fiber	21g
Protein	21g
Sodium	490mg

Adapted from [wholefoodsmarket.com](https://www.wholefoodsmarket.com)



Financial Focus

Pumpkin Spice Lattés: How to Sip & Save This Fall

As summer fades to fall, there's a certain vibe in the cooler air marked by cozy sweaters, colorful leaves and the aroma of pumpkin spice lattes brewing in your local coffee shop. This fan favorite has captured many hearts and taste buds as a seasonal indulgence not to be missed.

An occasional pumpkin spice latte can be an affordable treat. According to [CNN Business](#), the average price of a medium pumpkin spice latte in 2022 rang in at just under \$6.00. This may not seem like a lot and, therefore, can feel easy to spend often. However, these small amounts can add up quickly — whether spent or saved.

The data shows that consistently saving even small amounts can add up significantly over time, especially when building your retirement fund. Consider some of the benefits of making regular, small contributions into your employer-sponsored retirement plan while still enjoying your occasional treat.

The Power of Compound Interest

When you save money consistently in your retirement account, you benefit from the power of compound interest. This allows your money to potentially grow exponentially over time, as both your contributions and the returns on your investments generate additional earnings. By starting early and contributing even a small amount regularly, you can significantly boost your retirement savings. The longer your money remains invested, the greater the impact of compound interest on your overall returns.

Dollar-Cost Averaging

Regular contributions to your account allow you to take advantage of a strategy called dollar-cost averaging. This involves investing a fixed amount of money at regular intervals, regardless of market conditions. When the market is down, your contributions can buy more shares at a lower price. Dollar-cost averaging helps reduce the impact of market fluctuations on your overall investment performance and instills discipline in sticking to your investment plan.

Tax Benefits & Potential Employer Matching Contributions

Making contributions to your retirement plan has tax benefits, depending on the type of contribution you're making. They may either lower your current tax liability or allow for tax-free withdrawals when certain conditions are met. These benefits can allow you to save more effectively. Additionally, many employers offer matching contributions, where the organization matches your contributions up to a certain percentage, which can accelerate savings.

Mindful Spending (& Saving) Habits

Whether it's ordering fewer lattes, packing a lunch instead of eating out or cutting back on streaming apps, reviewing your budget and adopting a practice of mindful spending will help prioritize saving for your future and lead to better money management overall. Also, spending money on things that bring joy as opposed to impulsive or unnecessary spending can improve financial health and contribute to your overall wellbeing.

Saving money is a skill that requires discipline and long-term vision.

While it may seem insignificant to save small amounts (like the cost of a latte), don't underestimate the power of these savings. Over time, small contributions can help you accumulate your retirement nest egg.

Contribution	Reduction in Take-home Pay per Week	Projected Savings at Retirement
1%	\$3.61	\$44,368
2%	\$7.22	\$88,736
3%	\$10.83	\$133,104
5%	\$18.05	\$221,840

Tax bracket which includes local, state and federal: 25% | Annual income: \$25,000
Years to retirement: 30 | Annual rate of return: 8% | Rate of pay increases annually: 2%

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Parental Self-Care for Back to School



With school days in full swing throughout the country, fall can be an overwhelming time of year for parents and children. Coming on the heels of what is often a more relaxed summer schedule, it can feel challenging to get back into the groove — from the prep of gathering school supplies, attending parent meetings and syncing family schedules to coordinating lunches, drop-offs, pick-ups, sports and more.

While we don't always have control over school and work schedules, by building in space to practice self-care and prepare for the school routine, the school year can feel more manageable. Here are some helpful tips to help you slow down while keeping up with the demands of the school year.

Don't let your kids be your alarm clock. Ideally, wake up an hour before needed to allow yourself time to start the day calmly. Read the paper or a favorite book, enjoy a hot cup of coffee or tea, or go for an invigorating run in the stillness of the early morning.

Get oriented. Give yourself ample time to get used to the new routine. Do a timed trial run of how long it takes to get everyone up, ready, out the door and driven to school and work. Build in extra time to allow for the unexpected, such as traffic, forgotten homework and the like.

Block off your calendar and get back-up help. Create appointments on your calendar for school drop-offs and pick-ups, school room volunteering, sporting events, etc. Arrange plans with a spouse, family member, friend, babysitter or neighbor to provide back-up help when needed.

Prepare. If your child takes a lunch from home, make it the night before (perhaps as a family activity) or Google healthy meal prepping for ideas that will make lunch-making a breeze.

Practice an attitude of gratitude. Shut down the electronics at least an hour before bed and spend a few moments writing down a few things from the day for which you are grateful. This can also be a meaningful dinner ritual with your family and/or bedtime ritual with your children.

If adding in these tips feels overwhelming, try starting with whichever you feel most drawn to and give yourself time to see how it feels and what difference it makes. Or come up with your own ways to create space and make life more manageable.

Lastly, keep in mind that while most parents consider their own needs as secondary to their children's, with little eyes watching and emulating your every move, your children will likely learn the invaluable lessons of being present, calm and prepared, as well.

The Buzz About Blue Light-Blocking Glasses



If you've been looking for relief from eye strain or poor sleep quality, chances are you've run across the latest trend in wellness — blue light-blocking glasses. They're designed to lessen the amount of blue light (short-wavelength light) that the wearer is exposed to and marketed as a means of alleviating eyestrain and associated conditions (e.g., headaches, dry eye) and improving sleep quality.

While we're exposed to blue light in many forms, the amount omitted by electronics is the subject of scrutiny. Researchers agree that blue light from LED devices, such as laptops and smart phones, may block the body's natural production of the sleep-aiding hormone melatonin. While the simple solution is to limit screen time (or at minimum, adjust screen brightness settings) a few hours before bed, people are searching for alternative solutions that don't involve changing habits of device use.

Blue light-blocking lenses may appear to be a logical option for solving this shortage of melatonin creation; however,

quality research to support the theory is still somewhat lacking, and the market is fairly unregulated, making it difficult to know and control the quality of the glasses available. A 2017 meta-analysis conducted by the College of Optometrists found "a lack of high-quality evidence to support using blue light-blocking spectacle lenses for the general population to improve visual performance or sleep quality, alleviate eye fatigue or conserve macular health."

Further, The American Academy of Ophthalmology has gone on record saying they do not recommend any kind of special eyewear for computer users, stating, "The symptoms of digital eye strain are linked to how we use our digital devices, not the blue light coming out of them."

Despite the lack of evidence in favor of blue light-blocking lenses, countless users testify that they suffer less eye strain and other symptoms after wearing them. The bottom line: Speak with your doctor about your best options if you're struggling with eyestrain, poor sleep, headaches or other symptoms. You can also try these tips for reducing eyestrain associated with prolonged device use:

- Adopt the 20-20-20 rule, recommended by many vision-related organizations. Every 20 minutes, look at an object at least 20 feet away for 20 seconds.
- Adjust your seat or the position of your computer so your eyes are about 25" from the screen. Position the screen so you're gazing slightly downward.
- Use a matte screen filter to reduce glare.
- Use artificial tears when your eyes feel dry. Blinking, which keeps our eyes lubricated, can drop by up to 50% when focusing intensely on a computer screen.
- Pay attention to the lighting in the room. You might try increasing your screen contrast. Ensure you're not staring at a bright screen in a dark room.

The *Wellbeing Insights* Newsletter is prepared for you by CBIZ. The contributions included in this newsletter do not specifically reflect your employer's opinions. Consult your health care provider before making any lifestyle changes.

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Visit the **CBIZ Engagement & Wellbeing website**
at cbiz.com/wellbeing.



SECTION 3

COMPLIANCE DOCUMENTS SAMPLES



IN THIS YEAR-END EDITION:

❖ STATUS UPDATES:

- ♦ Wellness Programs
- ♦ HIPAA Privacy and Security Rules
- ♦ Retirement Plan Matters
- ♦ Paid Leave

❖ AT-A-GLANCE TABLES AND CHARTS:

- ♦ 2019 Inflationary Adjustments applicable to Welfare and Pension Plans
- ♦ Welfare Benefit Plan Reporting Reminders
- ♦ Annual Welfare Benefit Plan Disclosure Reminders
- ♦ Determining Applicable Covered Employer Status of Certain Laws
- ♦ Increased Penalties for Certain Compliance Failures

Looking back over 2018 and forward to 2019, a word that comes to mind is *interesting*. Merriam-Webster defines this adjective as “*holding the attention, or arousing interest or a feeling that accompanies or causes special attention to an object or class of objects*”.

Specific to the employee benefits arena, efforts to repeal, replace, or repeal and replace the Affordable Care Act has moved from the Congress, albeit several attempts failed in 2017, to the Executive Branch and the courts. For a glimpse of these actions, see *The Affordable Care Act – A Year in Review* from our [*CBIZ Health Reform Bulletin 142*](#).

This notwithstanding, the administrative agencies and the courts have taken the position that ‘*we say what we mean, and mean what we say*’. An example of this mantra has been made clear in the wellness program arena.

Wellness Programs

As a reminder, many laws govern wellness programs including the Americans with Disabilities Act (ADA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Genetic Information Nondiscrimination Act of 2008 (GINA), the Affordable Care Act (ACA), the Age Discrimination in Employment Act (ADEA), as well as many state employment discrimination laws. It is imperative that the plan design comply with all applicable laws. Compliance with one law does not mean compliance with other relevant laws.

Of particular note, the HIPAA-ACA rules apply when a wellness program is part of a health plan; the ADA and GINA rules apply without regard to whether a wellness program is part of health plan. Further, the rules create differences in the offering of wellness incentives.



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Continued from Page 1

ADA-GINA Rules. As a quick review, the Equal Employment Opportunity Commission's (EEOC) wellness program rules specific to the ADA restrict incentives used to encourage participation in wellness programs when individuals are required to respond to disability-related inquiries and/or undergo medical examinations. The EEOC's rules relating to GINA address permissible incentives relating to spouses of employees who participate in employer-sponsored wellness programs. In August, 2017, the U.S. District Court for the District of Columbia vacated a portion of the EEOC's wellness program rules in the *AARP v. EEOC* case; specifically, any wellness incentive based on the collection of medical information derived from a disability-related inquiry or medical examination will not be permitted beginning January 1, 2019.

The Court further directed the EEOC to re-evaluate other aspects of its 2016 rules, specifically, the 30% ceiling on the use of incentives, rewards or penalties for participation in a wellness program. These revised rules were initially designated for release sometime in January, 2019. However, according to the EEOC's Fall Regulatory Agenda, these regulations are not expected to be released until summer, 2019, leaving employers in continued limbo.

HIPAA-ACA Rules. The HIPAA and ACA rules, though, are in full force and effect. A number of recent actions provide a good reminder of the importance to comply with the rules. Generally, the HIPAA nondiscrimination rules require that if a program is contingent, i.e., activity-based or based on achieving an outcome, several requirements apply:

1. The reward, taken together with all rewards from other wellness programs, cannot exceed 30% of the cost of single coverage; or, if the wellness program is made available to the family, then the cost of the relevant coverage (for example, full family, or individual plus one). If the program relates to tobacco-free standards, the incentive can be as much as 50%.
2. The program must be reasonably designed to promote health or prevent disease, and cannot be overly burdensome.
3. The program must give individuals the ability to qualify for the program, at least once annually.
4. The program must be available to all similarly situated individuals and offer a reasonable alternative method of compliance in appropriate circumstances.

Specific to activity-only programs, a reasonable alternative (or waiver of the applicable standard) must be offered to any individual for whom it is unreasonably difficult to satisfy the program criteria due to a medical condition. A reasonable alternative method or waiver must be offered in outcome-based programs if the individual does not achieve the requisite goal or outcome, without regard to whether the cause is due to a medical condition.

5. Plan materials describing wellness programs must include a notice of available alternative options about how to qualify for a reward if an alternative option is recommended by a participant's health care provider, or otherwise available through the wellness program.

Litigation and Regulatory Oversight. Both the courts and the Department of Labor (DOL) are saying loud and clear that the reasonable alternative requirement is mandatory. For example:

The DOL challenged Macy's benefit package specifically relating to its smoking cessation component of its wellness program in a civil action complaint filed on August 16, 2017 in the U. S. District Court for the Southern District of Ohio (*Acosta v. Macy's Inc.*, S.D. Ohio, No. 1:17-cv-00541). The challenge alleged that Macy's failed to provide a reasonable alternative to participants which would have enabled them to avoid a tobacco surcharge, ranging from \$35 to \$45, for those who failed to meet the standards of Macy's tobacco cessation program. As mentioned above, a contingent wellness program, whether activity or outcome-based, must provide a reasonable alternative to individuals under certain circumstances. Generally, a smoking cessation program can qualify as a reasonable alternative. The DOL alleged that Macy's continued to charge the smokers the higher rate without giving them an opportunity to achieve the reward.

Similarly and more recently, the DOL alleged that the fiduciaries of a group health plan breached their duty for failure to provide a reasonable alternative standard, or waiver, to plan participants [*Acosta v. Dorel Juvenile Grp., Inc.* [Civil Action Case No. 1:18-cv-02993-JRS-MJD (S.D. Ind. 2018)]]. In this matter, plan participants of the wellness program were required to pay a tobacco surcharge as part of their medical insurance premium over a five-year period, without a reasonable alternative to achieving the goal.

The Court determined that the wellness program violated the HIPAA nondiscrimination rules based on health status, as well as failed to provide a reasonable standard, and **ordered** the plan sponsor to pay restitution of \$145,635 to the 596 employees who paid a tobacco-use surcharge. Further the parties agreed to a reduced penalty assessment of over \$14,000. In addition, the plan sponsor is ordered to amend the terms of its wellness program to ensure that plan participants who utilize a reasonable alternative earn the same reward as non-tobacco users, and that the wellness program cannot require attestation of tobacco-free use more than once per plan year.

In a related civil action, the DOL sued an Ohio-based corporation over its wellness program design, again citing violation of the HIPAA nondiscrimination rules based on health status, as well as breach of fiduciary duty by the plan sponsor. In the matter of *United States Department of Labor v. Chemstation International, Inc. et al* [Docket No. 3:18-cv-00338 (S.D. Ohio Oct 15, 2018)], the company sponsors a self-insured group health plan, together with a rewards-based wellness program. Employees participating in the wellness program would receive premium discounts toward health coverage as long as they attained and maintained a specified number of healthy outcomes, such as body mass index, blood pressure, LDL cholesterol and glucose levels, as well as for nonuse of tobacco products. Those who failed to maintain healthy outcomes or declined to participate in the wellness program were charged higher premiums for health coverage. The company did not offer a reasonable alternative way for individuals to achieve the reward as required by the HIPAA law. The parties settled the matter on October 17, 2018. In accordance with the terms of the court order, Chemstation is required to pay \$59,189 reflecting excess withheld premium and lost opportunity costs directly to the affected current and former participants.

HIPAA Privacy and Security Rules

The HIPAA privacy and security rules have been in force over 15 years. These rules govern the protection of individually identifiable medical information (PHI), set forth national standards for electronic transactions, and provide standards for securing PHI held in electronic form.

The HHS Office of Civil Rights (OCR) continues to enforce and investigate violations of these rules. For the period of April 2003 through July 2018, the OCR received 186,453 violation complaints.

Of a total of 37,670 complaints investigated, corrected action had been achieved in 69% of the violations, with 31% returned finding no violation. OCR continues to impose sanctions for HIPAA privacy violations. One of the largest HIPAA violation settlements occurred in October of this year when Anthem settled its health data breach for a record \$16 million.

To keep up with the changing times, the OCR is currently seeking **public input** in an effort to fine-tune its privacy and security rules to encourage coordination of health care while protecting patient information. Specifically, the OCR is seeking ways to:

1. Encourage information-sharing for treatment and care coordination;
2. Facilitate parental involvement in care;
3. Address the opioid crisis and serious mental illness;
4. Coordinate disclosures of PHI for treatment, payment, and health care operations as required by the HITECH Act; and
5. Change the current requirement for certain providers to make a good faith effort to obtain an acknowledgment of receipt of the Notice of Privacy Practices.

Retirement Matters

Retirement and savings plan laws have not seen significant changes since the Pension Protection Act of 2006 was signed into law by President George W. Bush on August 17, 2006. This year, several pieces of legislation were introduced in both the Senate and the House that could foretell some retirement plan changes in 2019.

Without going into detail about specific bills, the topics receiving bipartisan support include efforts to facilitate and empower employers, particularly small employers, to offer retirement savings type plans, and to encourage individuals to save.

Concepts currently receiving bipartisan support are three-fold:

1. Enhance the ability to offer multiple employer retirement plans or association retirement plans (ARP), and relieve individual employers from certain fiduciary liability in an effort to allay the fear of offering retirement plans to employees;
2. Enhancement of automatic contribution features to persuade the inertia that is natural to human nature and encourage greater savings; and



- Enhancement of electronic distribution of materials, which may also ultimately impact the welfare benefit arena. Recognizing the evolving world in which we live, there is great demand to facilitate electronic distribution of retirement plan documents to participants.

It is very possible that some form of these retirement plan concepts will receive attention in 2019.

Paid Leave

Paid leave continues to be the topic of the day, and such concepts continue to be enacted and implemented in the state and local level, both in the form of earned sick leave and paid family leave. These measures continue to create some angst and coordination issues, particularly for multi-jurisdictional employers. Following is a brief round-up of new laws this year:

♦ *Paid Sick Leave Law Changes in 2018*

Local jurisdictions enacting an earned sick leave benefit this year include Westchester County, New York, and the City of Duluth. New York City amended its current paid sick leave ordinance to allow use of accrued paid sick leave as safe leave beginning in May.

While both Austin and San Antonio enacted earned sick leave ordinances this year, the Texas Third Circuit Court of Appeals deemed Austin's ordinance to be unconstitutional. The Texas Legislature is expected to take up a bill in its 2019 legislative session that would preclude local jurisdictions from passing these types of laws. Another domino effect resulting from enacting this bill would be the potential impact on San Antonio's paid sick leave ordinance, which is set to take effect on August 1, 2019.

On the *state level*, Michigan enacted a state-wide paid sick leave law on December 14, 2018. Also this year, New Jersey's statewide paid sick leave law took effect on October 29th, Rhode Island's law took effect on July 1st and Maryland's law became effective on February 11th. Washington's state-wide paid sick leave law takes effect on January 1, 2019.

♦ *Paid Medical and Family Leave Changes in 2018*

New York's paid family leave benefit took effect on January 1 of this year, as well as the expansion of job-protected unpaid parental leave in California applicable to small employers.

Here's a look at the current status of state and local sick and family leave laws. For more information about these types of laws, contact your CBIZ representative. Also note, on an on-going basis, we include summaries of state and local paid leave changes in our *monthly Benefit Beat newsletters*.

States with Paid Medical and Family Leave Laws

California
District of Columbia
Massachusetts
New Jersey
New York
Rhode Island
Washington

States with Earned or Paid Sick Leave Laws

Arizona
California
Connecticut
District of Columbia
Massachusetts
Michigan
New Jersey
Oregon
Rhode Island
Vermont
Washington

Cities or Counties with Earned or Paid Sick Leave Ordinances

State	City or County
California	Berkeley, Emeryville, Los Angeles, Oakland, San Diego, San Francisco and Santa Monica
Illinois	Cook County and City of Chicago
Maryland	Montgomery County
Minnesota	Cities of Duluth, Minneapolis and Saint Paul
New Jersey	Paid sick leave ordinances of 13 local jurisdictions superseded by state paid sick leave law, which took effect Oct. 29, 2018
New York	New York City and Westchester County
Pennsylvania	Philadelphia and Pittsburgh* (*Implementation date of Pittsburgh ordinance suspended; currently under court review)
Texas	Austin and San Antonio (Implementation date of both City ordinances currently suspended)
Washington	Seattle and Tacoma (Spokane ordinance sunset Dec. 31, 2017-superseded by state paid sick leave law which took effect on Jan. 1, 2018)

On the **federal level**, Congress is also considering enacting some form of nationwide paid family leave law, such as requiring employers to offer a minimum number of compensable leave days per year, with the goal to make the program exempt from current local and state paid leave laws.

As incentive for employers to provide paid family and medical leave to their employees, the Tax Cuts and Jobs Act enacted last December added a new tax credit for wages paid to qualifying employees during any period in which an employee is absent from work due to a family and medical leave event. An employer is eligible for a general business tax credit under Code Section 45S if it has a separate written policy in place that allows all qualifying full-time employees a minimum of two weeks of annual paid family and medical leave. This credit is available to an employer without regard to whether it is subject to the federal Family and Medical Leave Act (FMLA), as long as the employer maintains the written policy that meets the wage payment criteria.

The credit generally is effective only for wages paid in taxable years of the employer beginning after December 31, 2017, and before January 1, 2020. The IRS provides additional information about this credit on its website in an [FAQ format](#).

TABLES AND CHARTS

In closing, from the esoteric to the mundane, the following pages contain a few 'at-a-glance' tables and charts reflecting:

- ♦ 2019 inflationary adjustments applicable to welfare and pension plans,
- ♦ Welfare benefit plan reporting reminders,
- ♦ Annual welfare benefit plan disclosure reminders,
- ♦ Determining applicable covered employer status of certain laws, and
- ♦ Increased penalties for certain compliance violations.

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2019 Inflationary Adjustments - Welfare Benefit Plans

	2019	2018		
FSA CAP				
Limit on health flexible spending account (FSA) dollars via voluntary salary reductions	\$2,700	\$2,650		
QUALIFIED TRANSPORTATION FRINGE BENEFITS				
Commuter Highway Vehicle (van pooling) and Any Transit Pass	\$265	\$260		
Qualified Parking	\$265	\$260		
QUALIFIED ADOPTION ASSISTANCE REIMBURSEMENT PROGRAM (IRC §137)				
Exclusion Limit	\$14,080	\$13,840		
AGI Phase-out Limits	Between \$211,160 and \$251,160	Between \$207,580 and \$247,580		
HEALTH SAVINGS ACCOUNTS	<i>Individual</i>	<i>Family</i>	<i>Individual</i>	<i>Family</i>
HDHP Annual Deductible	\$1,350	\$2,700	\$1,350	\$2,700
HDHP Annual Out-of-Pocket Limit	\$6,750	\$13,500	\$6,650	\$13,300
Contribution Limit	\$3,500	\$7,000	\$3,450	\$6,900
ACA PLANS - OUT-OF-POCKET LIMITS				
<i>Applicable to insured plans offered via the marketplace, and insured and self-funded plans offered outside marketplace</i>	<i>Self-only</i>	<i>Family</i>	<i>Self-only</i>	<i>Family</i>
	\$7,900	\$15,800	\$7,350	\$14,700
QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS	<i>Employee-only</i>	<i>Employee's Family Members</i>	<i>Employee-only</i>	<i>Employee's Family Members</i>
Cap on annual amount of payments and reimbursements	\$5,150	\$10,450	\$5,050	\$10,250
ARCHER MEDICAL SAVINGS ACCOUNTS	<i>Individual</i>	<i>Family</i>	<i>Individual</i>	<i>Family</i>
HDHP Annual Deductible	Between \$2,350 and \$3,500	Between \$4,650 and \$7,000	Between \$2,300 and \$3,450	Between \$4,550 and \$6,850
Out-of-Pocket Expenses	\$4,650	\$8,550	\$4,550	\$8,400
LONG-TERM CARE PREMIUMS				
Under age 40	\$420		\$420	
>40 but <50	\$790		\$780	
>50 but <60	\$1,580		\$1,560	
>60 but <70	\$4,220		\$4,160	
Over age 70	\$5,270		\$5,200	



2018 Inflationary Adjustments - Medicare Parts A and B

	2019	2018
Medicare Part A		
Premium	- No monthly Part A premium for those with 40+ quarters of Medicare-covered employment - If buys Part A: 30-39 quarters: \$240/month <30 quarters: \$447/month	- No monthly Part A premium for those with 40+ quarters of Medicare-covered employment - If buys Part A: 30-39 quarters: \$232/month <30 quarters: \$422/month
Deductible	\$1,364 for first 60 days of inpatient care - Additional \$341 per day for days 61 through 90 - Additional \$682 per day beyond the 90th day	\$1,340 for first 60 days of inpatient care - Additional \$335 per day for days 61 through 90 - Additional \$670 per day beyond the 90th day
Medicare Part B		
Premium (may be higher depending on income)	\$135.50 per month	\$134 per month
Deductible	\$185 per year	\$183 per year

2019 Inflationary Adjustments - Pension and Retirement Plans

	2019	2018
♦ Defined benefit plan annual limit	\$225,000	\$220,000
♦ Defined contribution plan annual limit	\$56,000	\$55,000
♦ Elective deferral limit for purposes of cash or deferred arrangements (401(k) plans) and tax-sheltered annuities (403(b) plans)	\$19,000	\$18,500
♦ Maximum deferral limit for 457 plans	\$19,000	\$18,500
♦ Over-age 50 catch-up contribution limit to 401(k), 403(b) or 457(b) plans	\$6,000	\$6,000
♦ Maximum deferral limit for SIMPLE plans	\$13,000	\$12,500
♦ Over-age 50 catch-up contribution limit to SIMPLE plans	\$3,000	\$3,000
♦ Minimum compensation considered in determining eligibility for a SEP (simplified employee pension)	\$600	\$600
♦ Threshold for highly compensated employee (HCE)	\$125,000	\$120,000
♦ Key employee compensation limit for top heavy plan purposes	\$180,000	\$175,000
♦ Annual compensation limit	\$280,000	\$275,000



Welfare Benefit Plan Reporting Reminders

Form	To Whom	Due Date
Form 5500	Department of Labor – Employee Benefit Security Administration (EBSA) http://www.efast.dol.gov	Within 7 months of end of plan year
Form M-1 (Form M-1 filers must also file Form 5500)	EBSA http://www.askebsa.dol.gov/mewa/	March 1 of each year
Form W-2 <i>Welfare benefit plan reporting includes:</i> ◆ Aggregate cost of health coverage (Box 12, using Code DD). Note, employers filing <250 Form W-2s per year remain exempt from reporting the aggregate cost of health coverage on the Form W-2 until future IRS guidance is issued. ◆ HSA employer contributions plus amounts employees elect to contribute via an IRC §125 cafeteria plan (Box 12 - Code W) ◆ Total amount of permitted benefits received under a qualified small employer health reimbursement arrangement (QSEHRA) (Box 12 - Code FF) ◆ Disability income/sick pay benefits received by from third party payer ◆ Amounts reimbursed via dependent care assistance program plus amounts exceeding maximum \$5,000 exclusion (include in Boxes 1, 3 and 5) ◆ Cost of group term life insurance over \$50,000 (Table I rates) reported in Boxes 1, 3 and 5; and Box 12 - Code C ◆ Additional Medicare tax withholding on earnings exceeding \$200,000 per calendar year (Box 6)	Internal Revenue Service (IRS) http://www.irs.gov/ Form W-2 Instructions (2018)	January 31, 2019
Form 1094/1095		
File Forms 1094/1095	IRS	◆ By paper: February 28, 2019 ◆ Efile: April 1, 2019
Furnish Form 1095	Individuals listed in Forms 1094 and 1095	Due date extended from Jan. 31, 2019 to March 4, 2019
Form 720 for purposes of Patient Centered Outcome Research (PCOR) fee	IRS	July 31 st of each year
Medicare Part D Creditable Coverage Form http://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html	Centers for Medicare & Medicaid Services (CMS)	Within 60 days of the commencement of the plan year

Annual Welfare Benefit Plan Disclosure Reminders

<i>Document</i>	<i>To Whom</i>	<i>Timeframe</i>
Summary Annual Report (applicable to plans filing Form 5500)	Plan participants and certain beneficiaries	Annually - within 9 months after close of plan year
Annual Women's Health and Cancer Rights Act (WHCRA) Notice	Plan participants and certain beneficiaries	Annually
Medicaid/CHIP Premium Assistance Notice (available in <i>English & Spanish</i>)	All employees living in states providing premium assistance	Annually
Medicare Part D Creditable Coverage Disclosure Notice	All Medicare-eligible individuals including current and former employees and Medicare-eligible dependents covered by plan or become eligible to enroll in plan	Annually
Summary of Benefits and Coverage (SBC) Available from <i>DOL</i> and <i>HHS</i>	All plan participants	Annual disclosure if related health plan contract renews on annual basis

Determining Applicable Covered Employer Status

<i>Law</i>	<i>Employee Threshold</i>
Affordable Care Act – Employer Shared Responsibility Penalty	50 full-time employees or full-time equivalent employees. Review number of employees at end of each calendar year for purposes of determining whether the shared responsibility requirements apply in following year
Age Discrimination in Employment Act (ADEA)	- State and local governments without regard to the number of employees; and - Private sector employers engaged in a business or industry affecting interstate commerce, who employ 20 or more employees on 20 or more calendar weeks in the current or preceding calendar year.
Americans with Disabilities Act (ADA)	15 or more employees on 20 or more calendar weeks in the current or preceding calendar year
Consolidated Omnibus Budget Reconciliation Act (COBRA)	20 or more common law employees on at least 50% of the business days in the preceding calendar year; includes full-time, part-time, and seasonal employees
Family and Medical Leave Act (FMLA)	Applies to public and private employers who employ 50 or more employees on each working day in 20 or more calendar weeks in current or preceding calendar year
Health Insurance Portability and Accountability Act (HIPAA)	Applies to all public and private employers employing at least two participants who are current employees
Medicare Secondary Payor Rules (MSP Rules)	<i>Medicare due to age</i>: 20 or more full or part-time employees on at least 20 calendar weeks in current or preceding calendar year <i>Medicare due to disability</i>: 100 full or part-time employees on at least 50% of regular business days in preceding calendar year <i>Medicare due to end-stage renal disease</i>: Applies without regard to employer size

Determining Applicable Covered Employer Status, cont'd

<i>Law</i>	<i>Employee Threshold</i>
Pregnancy Discrimination Act (PDA)	Public sector employers, and private sector employers engaged in a business or industry affecting interstate commerce, who employ 15 or more employees on each working day in at least 20 or more calendar weeks in the current or preceding calendar year. The law does not apply to the federal government, Indian tribes, or a department or agency of the District of Columbia.
Uniformed Services Employment and Reemployment Rights Act (USERRA)	Applies to all public and private employers, regardless of size

Increased Penalties for Certain Compliance Violations

Federal government agencies who enforce the law, including the Departments of Labor, Treasury and Health and Human Services, and the Equal Employment Opportunity Commission, have authority to adjust civil penalties attributable to compliance failures. As a general rule, the DOL and EEOC announce their respective adjusted penalties in January of each year; thus, at the time of this writing, the 2019 amounts have not been announced yet, and designated "to be determined"(TBD) below.

	2019 Penalty Amount	2018 Penalty Amount
Failure or refusal to file the annual Form 5500	TBD (minimum of 2018 amount)	Up to \$2,140 per day
Failure to file Form M-1	TBD (minimum of 2018 amount)	Up to \$1,558 per day
Failure to provide Summary of Benefits and Coverage (SBC)	TBD (minimum of 2018 amount)	Up to \$1,128 per failure
Failure to notify employees of Medicaid Premium Assistance and CHIP coverage opportunities	TBD (minimum of 2018 amount)	Up to \$114 per day
Failure to file a correct information return (Examples: Forms 1094/1095 and W-2)	\$270 per return (total penalty cap of \$3,339,000 per calendar year)	\$270 per return (total penalty cap of \$3,275,500 per calendar year)
Failure to provide correct payee statement (Examples: Forms 1094/1095 and W-2)	\$270 per statement (total penalty cap of \$3,339,000 per calendar year)	\$270 per statement (total penalty cap of \$3,275,500 per calendar year)
Failure to comply with protections afforded under Genetic Information Nondiscrimination Act (GINA)	TBD (minimum of 2018 amount)	Up to \$114 per day of noncompliance
Failure to post the Family and Medical Leave Act workplace posting	TBD (minimum of 2018 amount)	Up to \$169 per separate offense
Failure to post the EEOC workplace posting, "Equal Employment Opportunity is the Law"	TBD (minimum of 2018 amount)	\$545 per violation



Subject: **1) Status of ACA Litigation; 2) Murky Future of AHPs; 3) Benefit and Payment Parameters for 2020; and 4) Extended Transition Period for ACA Compliant Policies**
Date: May 10, 2019

Status of ACA Litigation

Litigation challenging and rescinding various aspects of the Affordable Care Act (ACA) continues to reign. Last December, Judge Reed O'Connor of the Fifth Circuit Court of Appeals opined that the individual mandate, in the absence of the tax repealed by the Tax Cuts and Jobs Act, is unconstitutional; and since it is a cornerstone of the ACA, then the entire ACA must fall (see our prior [CBIZ Health Reform Bulletin 142](#)). Briefs to appeal the Court's ruling were submitted on May 1, 2019 by a collective group of State Attorneys General, as well as individuals. Of particular note, the Department of Justice (DOJ) also filed its brief stating that it would no longer defend any aspects of the law whereas previously, the DOJ indicated it would defend certain aspects of the law. Oral arguments on the matter is expected to begin the week of July 8, 2019.

Meanwhile, the law continues to be in full force and effect.

Murky Future of Association Health Plans

The future of formation and operation of association health plans is in a state of quagmire. Last year, the Department of Labor (DOL) released rules to permit formation of an amplified version of association health plans. For an overview of these rules, see our [CBIZ Health Reform Bulletin 139](#) (6/22/18) and the update contained in [HRB 142](#) (12/14/18). While newly formed association health plans have been established pursuant to the amplified rules, there are a number of legal challenges being raised.

As background, generally, ERISA applies to single employer welfare benefit plans. A single employer includes a group of commonly controlled entities, as defined in IRC Section 414. When two or more unrelated employers participate in a single health benefit plan, a multiple employer welfare arrangement (MEWA) exists. In this instance, ERISA applies at the individual employer level unless the MEWA qualifies as a bona fide association. To qualify as a bona fide association, two requirements must be satisfied; a commonality of interest requirement, and a control test, as follows:

1. The *commonality of interest* requirement provides that the entity maintaining the bona fide association and the participating employers, must be tied by a common economic or representational interest beyond simply the provision of benefits. This is a facts-and-circumstances test; some of the factors considered in determining the commonality of interest test are:
 - ♦ How does the bona fide association solicit members?
 - ♦ Who is entitled to participate? Who actually participates?
 - ♦ How is the bona fide association formed?
 - ♦ What is the bona fide association's purpose?
 - ♦ What is the relationship of the participating members beyond the bona fide association membership?
2. The *control test* requires that the individual employer-members have the right to control and direct the activities of the plan, i.e., the bona fide association cannot exist for the primary purpose of offering health coverage.

If these two tests are not satisfied, then ERISA applies at the individual employer level. This means that each participating employer-member is responsible for its own 5500 requirement, its own disclosure requirements, such as plan documentation, summary plan descriptions, summary of material modifications, HIPAA compliance documents, compliance with the ACA, and so forth. The participating employer-members could appoint the association as plan administrator, which would make the association responsible for these disclosures. Conversely, if ERISA applies at the association level, then the association is responsible for these disclosures.

Amplified Association Health Plans

The regulations issued last summer expand the current criteria for establishing a bona fide association plan (referred to herein as “amplified AHP”) wherein ERISA would apply at the association level. These rules are intended to make it easier to satisfy the commonality of interest test for participating employers by limiting the standards to either a common geographic area or by common industries. Further, the regulations relax the control requirement test by indicating that the primary purpose of the association can be to provide group health benefits. Self-employed individuals are able to participate in these types of amplified AHPs even if the self-employed individual employs no employees.

A group or association of employers can establish an amplified AHP as long as it meets the following requirements:

1. The primary purpose of the group or association is formed for the purpose of offering and providing health coverage to its employer-members and their employees. While the primary purpose of an amplified AHP can be to offer employer-members health coverage, it must also have at least one *substantial business purpose* unrelated to offering and providing health coverage or other employee benefits, such as promoting common business or economic interest in a given trade or employer community. In addition, employer-members must meet a *commonality of interest standard*. This means that the employer-members be:
 - ♦ In the same trade, industry, line of business or profession; or
 - ♦ Each employer-member has a principal place of business in the same state or metropolitan area, even if it crosses state-lines, such as in the Washington D.C. or Kansas City metropolitan areas.
2. The functions and activities of the group or association, as well as the plan itself, is controlled by its participating employer-members. For this purpose, “control” is determined by a facts and circumstances test.

Legal Challenges

Following release of the DOL rules, 11 states and the District of Columbia challenged the authority of these amplified AHP regulations in *State of New York et al. v. United States Department of Labor et al* (Civ. Action 18-1747, D.C. D.C.J). On March 28, 2019, the U. S. District Court for the District of Columbia ruled on the matter.

First, the Court found that the DOL exceeded its authority in the broadened definition of “association”. Of particular concern to the Court is the lack of any significant commonality of interest standard as required by ERISA. As noted above, amplified AHPs can be established specifically for the purpose of providing health coverage, whereas ERISA requires bona fide association health plans to exist independent of the provision of health care. Further, the Court took exception with the new rules permitting self-employed individuals to participate in an amplified AHP because, by its very nature, ERISA is intended to specifically protect employee-participants.

The Court deemed certain parts of the amplified AHP regulations be vacated, i.e., held invalid; specifically, the broadened definition of “bona fide group or association of employers” and the “commonality of interest” provisions contained in the definition of employer, and the provisions relating to “dual treatment of working owners as employers and employees”.

The Court returned the amplified AHP regulations to the Department of Labor (DOL) for further consideration. Following the Court’s ruling, the DOL released a [statement of its position](#), together with [FAQs](#), relating to the effect of the court ruling on the matter. Accordingly, the agency intends to work with HHS, the states and other affected parties to minimize consequences of the conflict in the following ways:

- ♦ Insured AHPs formed in accordance with the DOL's amplified AHP regulations issued last year can continue coverage in force through the end of the plan year (or if later, the contract term). Beyond the end of the plan year or contract term, the coverage could be subject to ACA's insurance market reform rules applicable to small employer plans, essential health benefits, and premium rating rules.
- ♦ The DOL intends to make efforts to ensure claim payments incurred by current participants and beneficiaries covered under an amplified AHP are made.
- ♦ Further, no enforcement action will be made by the DOL for potential violations, as long as benefit claims continue to be made; and, as long as the amplified AHP-members show good faith reliance on the broadened rules through the end of the applicable plan year or contract term.

The future of existing AHPs formed in accordance with the amplified AHP regulations issued last year remains uncertain. Stay tuned for developments.

Benefit and Payment Parameters for 2020

The Department of Health and Human Services published its finalized **Benefit and Payment Parameters for 2020** on April 25, 2019, together with a **Fact Sheet**. These uniform standards, as required under the Affordable Care Act, are intended for health insurers and the marketplace to ensure health coverage options for consumers, as well as provide planning guidance for insurers and employers. Following are highlights of these rules:

- ♦ **Cost-sharing limits.** The ACA imposes certain cost-sharing restrictions, such as deductible and out-of-pocket limits on health plans. These annual out of pocket limits apply to insured plans offered through the marketplace, and insured and self-funded plans offered outside marketplace. Below are cost sharing limitations for 2018 through 2020:

	<i>Self-only Coverage (Individual)</i>	<i>Other than Self-only Coverage (Family)</i>
2018	\$7,350	\$14,700
2019	\$7,900	\$15,800
2020	\$8,150	\$16,300

As a reminder, the out-of-pocket (OOP) limits applicable to a high deductible health plan (HDHP) used in conjunction with a health savings account (HSA) differs from these ACA-imposed cost sharing limits. For 2019, the OOP limit for HDHP plans is \$6,750 for single coverage; \$13,500 for family coverage. It is anticipated that the IRS will release the 2020 inflationary adjustments applicable to HSAs in the near future.

- ♦ **Affordability standard – individual coverage.** The required contribution percentage by individuals for minimum essential health coverage (MEC) for purposes of determining eligibility for a hardship exemption under the individual shared responsibility requirement (IRC Section 5000A) occurs if the cost to the individual to purchase coverage exceeds 8.24% for 2020 (decreased from 8.30% in 2019) of household earnings.

This affordability standard is distinct from the employer's shared responsibility affordability standard, and distinct from the affordability standard for purposes of entitlement to premium assistance. For 2019, coverage under an employer-sponsored plan is deemed affordable to a particular employee if the employee's required contribution to the plan does not exceed 9.86% of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan.

- ♦ **Prescription Drugs.** Beginning in 2020, an insurer issuing both individual and group health plans of any size can, but is not obligated to, count manufacturer offsets, such as coupons and the like, toward an individual's maximum out-of-pocket limit under the health plan if there is a medically-appropriate generic drug available. The insurer cannot adopt these so-called accumulator programs if there is no generic equivalent available.
- ♦ **Benchmark Plan Designs.** Under current law, states can utilize one of several plan design categories for defining essential health benefits (EHB). A plan is permitted to use any of the 51 state-based benchmark plans, or the Federal Employee Health Benefit Plan benchmark plan to make its EHB determination.

The final 2020 benefit and payment parameters maintains these standards; as such, for plan years 2020 and beyond, states have the following additional options for selecting an EHB-benchmark plan. A state can:

- Select one of the 50 EHB-benchmark plans used by other states for the 2017 plan year;
- Replace one or more of the ten required EHB categories of benefits under its own benchmark plan used for the 2017 plan year, with the same categories of benefits from another state's EHB-benchmark plan used for the 2017 plan year; or
- Select a set of benefits tailored as its own EHB-benchmark plan, as long as it meets the scope of benefits requirements and other specified requirements, as outlined in [separate CMS guidance](#).

It is important to remember that a self-funded plan, even though it is not required to comply with all EHBs, must select a safe harbor benchmark plan against which it measures EHBs that it does, in fact, offer. This is relevant for a number of ACA purposes including restrictions relating to cost-sharing, annual and lifetime limits and preexisting condition exclusions.

- ♦ **Annual Open Enrollment Period.** For the 2020 plan year, the annual open enrollment period for obtaining coverage through the federal marketplace will run from November 1, 2019 through December 15, 2019. State marketplaces may have different open enrollment periods.
- ♦ **Special Enrollment Periods.** The final benefit and payment parameter rules establish a new special enrollment period for individuals who enroll in “off-exchange” individual coverage, and experience a sudden decrease in household income and are determined to be newly eligible for the advanced premium tax credit. The individual would have a 60-day special enrollment window, and must provide proof of the change in income, as well as proof of prior minimum essential coverage.
- ♦ **Federal Exchange User Fees.** Insurers participating in the federal marketplace are subject to a user fee to help pay for the operational expenses of the marketplace. For 2020, the user fee rate is reduced to 3.0% (3.5% for 2019) of the monthly premium charged by the insurer. Insurers in state-based exchanges that use the federal exchange platform will be charged 2.5% (down from 3.0% in 2019).

Extended Transition Period for ACA Compliant Policies

Certain so-called ‘grand-mothered’ policies in the individual and small group markets that are not grandfathered and have enjoyed exemption from some of the ACA’s insurance market reform provisions since January 1, 2014. The CMS’ Center for Consumer Information and Insurance Oversight has extended the exemption several times, and granted [another exemption](#) on March 25, 2019.

Accordingly, individual and small group health policies renewing prior to October 1, 2020 (but ending by December 31, 2020) can be renewed, free from many of the ACA’s market reforms, including:

- ♦ Fair health insurance premiums;
- ♦ Guaranteed availability of coverage;
- ♦ Guaranteed renewability of coverage;
- ♦ Prohibition of pre-existing condition exclusions or other discrimination based on health status with respect to adults, except with respect to group coverage;
- ♦ Prohibition of discrimination against individual participants and beneficiaries based on health status except with respect to group coverage;
- ♦ Non-discrimination in health care;
- ♦ Comprehensive health insurance coverage; and
- ♦ Approved clinical trials.

Unless extended again, or if changes are made by Congress or the Administration in the interim, beginning January 1, 2021, these policies must be ACA-compliant.

The information contained herein is not intended to be legal, accounting, or other professional advice, nor are these comments directed to specific situations. The information contained herein is provided as general guidance and may be affected by changes in law or regulation. The information contained herein is not intended to replace or substitute for accounting or other professional advice. Attorneys or tax advisors must be consulted for assistance in specific situations. This information is provided as-is, with no warranties of any kind. CBIZ shall not be liable for any damages whatsoever in connection with its use and assumes no obligation to inform the reader of any changes in laws or other factors that could affect the information contained herein.



SECTION 4

LICENSE COPIES FOR KEY PERSONNEL

OSCAR ANTHONY DIAZ
CBIZ BENEFITS & INSURANCE SERVICES, INC.
1765 E SKYLINE DR
TUCSON AZ 85718-1162

ARIZONA INSURANCE LICENSE

License No: 1291551

OSCAR ANTHONY DIAZ

CBIZ BENEFITS & INSURANCE SERVICES, INC.

1765 E SKYLINE DR
TUCSON AZ 85718-1162
RESIDENT

As of November 29, 2021

LICENSE CLASS	FIRST ACTIVE DATE	LICENSE EFFECTIVE DATE	LICENSE EXPIRATION DATE	LINES OF AUTHORITY	LOA EFFECTIVE DATE
Insurance Producer	10/31/1996	12/01/2021	11/30/2025	Accident and Health or Sickness Life	10/31/1996 10/31/1996

APPOINTMENT DATA IS NOT COLLECTED, TRACKED OR MAINTAINED IN ARIZONA.

Arizona Department of Insurance and Financial Institutions
100 N 15th Ave, Suite 261
Phoenix, AZ 85007-2630

JENNIFER JO ARAGON
CBIZ BENEFITS & INSURANCE SERVICES, INC
1765 E SKYLINE DR
TUCSON AZ 85718-1162

ARIZONA INSURANCE LICENSE

License No: 6746634

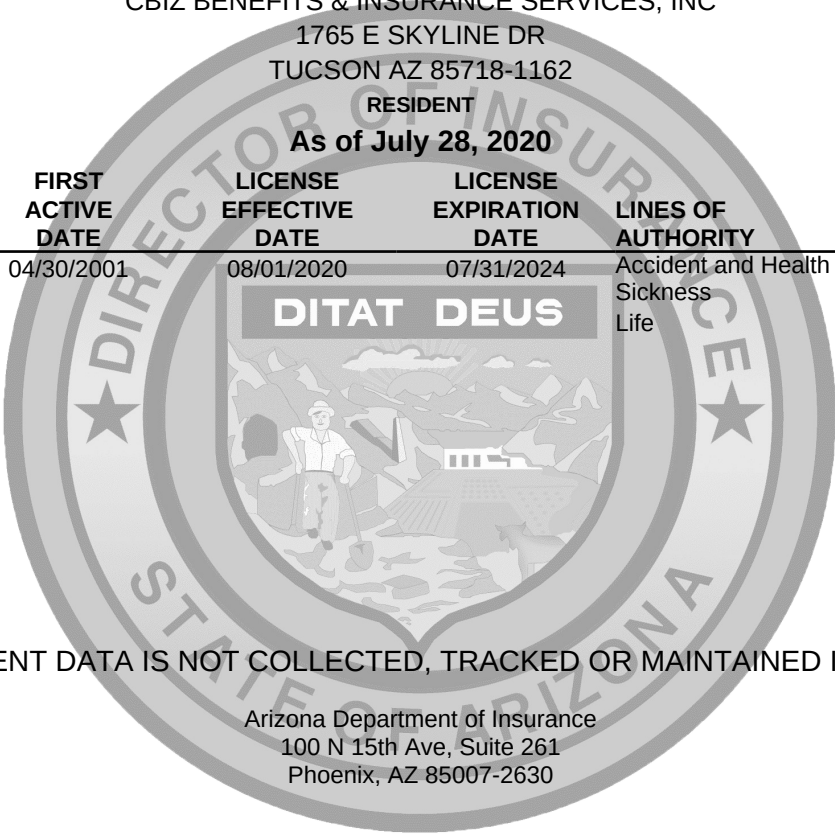
JENNIFER JO ARAGON

CBIZ BENEFITS & INSURANCE SERVICES, INC
1765 E SKYLINE DR
TUCSON AZ 85718-1162

RESIDENT

As of July 28, 2020

LICENSE CLASS	FIRST ACTIVE DATE	LICENSE EFFECTIVE DATE	LICENSE EXPIRATION DATE	LINES OF AUTHORITY	LOA EFFECTIVE DATE
Insurance Producer	04/30/2001	08/01/2020	07/31/2024	Accident and Health or Sickness Life	04/30/2001 04/30/2001



APPOINTMENT DATA IS NOT COLLECTED, TRACKED OR MAINTAINED IN ARIZONA.

Arizona Department of Insurance
100 N 15th Ave, Suite 261
Phoenix, AZ 85007-2630

DEBBIE MUELLER JAMISON
7080 E CALLE MORERA
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ARIZONA INSURANCE LICENSE

License No: 12109677

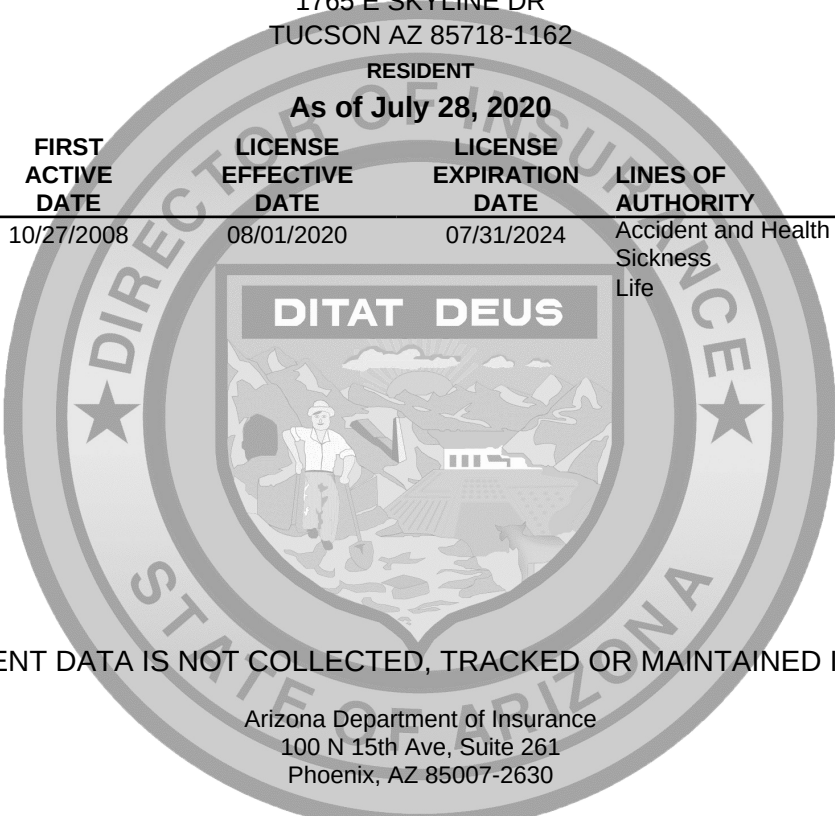
DEBBIE MUELLER JAMISON

1765 E SKYLINE DR
TUCSON AZ 85718-1162

RESIDENT

As of July 28, 2020

LICENSE CLASS	FIRST ACTIVE DATE	LICENSE EFFECTIVE DATE	LICENSE EXPIRATION DATE	LINES OF AUTHORITY	LOA EFFECTIVE DATE
Insurance Producer	10/27/2008	08/01/2020	07/31/2024	Accident and Health or Sickness Life	10/27/2008 10/27/2008



APPOINTMENT DATA IS NOT COLLECTED, TRACKED OR MAINTAINED IN ARIZONA.

Arizona Department of Insurance
100 N 15th Ave, Suite 261
Phoenix, AZ 85007-2630



SECTION 5

OFFEROR QUESTIONNAIRE

(EXHIBIT A)

EXHIBIT A – OFFEROR QUESTIONNAIRE

1. **Provide a comprehensive statement about your capacity to meet the City's needs as outlined in this RFP, emphasizing your range of services available to help us provide the best quality, breadth, and flexibility of coverage for our employees, while maximizing the value of our premium dollars. Outline specific details of each service you propose.**

Our local agency has been providing service to employers in Arizona for over 43 years. Our national CBIZ organization was founded in 1987 and the CBIZ Arizona office became part of CBIZ in 1991.

Who We Are Nationally

At CBIZ, your team starts with your local professionals but expands far beyond there. An entire group of specialized experts across the country stands ready to ensure all of your specific, unique business needs are met. CBIZ (NYSE: CBZ) is in the business of making things easier for our clients. As a leading provider of Employee Benefits Consulting Services, CBIZ is one of the nation's leading providers of professional advisory services, focused on accounting, benefits and insurance, HR, and payroll solutions. On a national basis, we employ over 6,000 associates engaged in a variety of disciplines.

Our corporate headquarters is located in Cleveland, Ohio, with the benefits consulting practice based in Kansas City, Missouri. CBIZ was founded in 1987 and our long-standing tenure as a top broker of U.S. Business allows us to navigate the complex and evolving insurance industry. We help our clients mitigate escalating health care costs through a creative benefits strategy, comprehensive and robust services, and reasonable fees.

Who We Are Locally

CBIZ Arizona is comprised of 47 dedicated staff members located in our Tucson and Phoenix offices. Our staff of professionals come from a wide variety of employee benefits, human resources, insurance carrier and wellbeing backgrounds. We believe that this diversity of experience enables our team to provide our clients with unique and varied approaches and strategies to meet their employee benefits needs, strategic goals, and objectives. Because of our size and reputation, CBIZ is recognized as a top broker/consultant by all of the major medical and ancillary carriers nationally and in the Arizona market.



The infographic titled "CBIZ Your Team." features a blue header with the CBIZ logo and the tagline "Your Team." Below the header, on the left, are statistics: "120+ offices", "6,500+ team members", and "100,000+ clients", accompanied by a map of the United States with office locations marked. A central box lists services under "FINANCIAL & ACCOUNTING" (Accounting & Tax, Government Health Care Consulting, Financial Advisory, Valuation, Litigation Support, Risk & Advisory Services, Tenant Advisory Services) and "Benefits & Insurance" (Benefits Consulting, Payroll Services, Human Capital Management, Property & Casualty, Retirement & Investment Solutions, Talent & Compensation Solutions, Individual Insurance). On the right, three green circular icons highlight achievements: "Top 15 Largest Accounting Provider Nationally", "Top 30 Largest Broker of U.S. Business", and "Top 3 Institutional Consulting Team". At the bottom right, two green icons represent "84 Workplace Awards in 2022" and "11 Million+ Lbs. of Food Donated since 2009". The footer includes the CBIZ logo, contact information (cbiz.com, 1-800-ASK-CBIZ), and social media links for Twitter, LinkedIn, and Facebook.

Services To Be Provided by CBIZ

1. **Plan Management and Renewals** - To ensure that the City of San Luis has a sustainable and attractive employee benefits program, CBIZ will:
 - Monitor and manage all renewals utilizing three (3) year strategies, timelines, benchmarking, and monitoring of key milestones
 - Assist with the development, issuance and review of RFPs and responses for all applicable lines of coverage
 - Provide carrier and vendor evaluations and implementation support
 - Provide monthly financial overviews and customized claims reporting
 - Conduct annual plan performance reviews
 - Provide benchmarking and data analytics
 - Assist with annual enrollment planning and attend annual enrollment meetings as needed
 - Assist with the development of annual enrollment communications materials and collateral
2. **Financial Management and Actuarial Services** – We will assess factors driving plan costs using financial projections and claims analysis through our in-house Analytics and Actuarial teams. We will also utilize this data to negotiate the best possible rates and claims liability factors for the City of San Luis. Some of the support will be to:
 - Provide both employer and employee contribution strategies, calculations, and migration studies
 - Provide annual funding projections and modeling capabilities utilizing certified actuarial practice
 - Provide reserve funding calculations
 - Provide plan and stop-loss insurance modeling, e.g., Monte Carlo studies
3. **Trust Management Assistance** – We will work with the City to provide its Trustees with relevant, meaningful, and actionable data and strategies and will:
 - Attend quarterly and other scheduled meetings to provide plan performance reporting
 - Provide and present relevant renewal information including specific plan/carrier/vendor renewals, funding projections, reserves estimates, IBNR studies, contribution options, plan and/or carrier change recommendations
 - Provide carrier/vendor/plan recommendations
 - Conduct a post-renewal medical plan Premium Adequacy Report
 - Present relevant employee benefits plan trends for all lines of coverage or benefits offered
4. **Day-to-Day Service and Carrier Management** – We will work closely with the City of San Luis's HR/Benefits and Finance department to:
 - Provide responses to benefits and compliance related inquiries
 - Provide assistance with carrier/vendor and plan issue resolution
 - Provide carrier/vendor management including holding carriers/vendors accountable for providing timely responses and resolutions
 - Provide access to CBIZ's in-house Claims Advocate
5. **Compliance and Regulatory Affairs** – We will help the City of San Luis to stay compliant with expert benefits, payroll, finance, tax, and regulatory assistance. We will do this by providing the City of San Luis with:
 - In-house regulatory affairs attorney and staff
 - Monitoring and communicating relevant state and federal regulations
 - Providing consistent compliance and Health Care Reform education materials through

newsletters, memos, and webinars

- Providing guidance on COBRA, HSA, FSA, FMLA, ACA and for other Federal regulations
- Providing guidance on State of Arizona specific regulations



Click on the QR code to view CBIZ's September 2023 Benefit Beat overview video. These videos are provided to our clients monthly.

6. **Communication and Education** – One of the hallmarks of the services that our Arizona office provide our clients is professionally developed communications and education materials. We will work with the City of San Luis to improve employee engagement by providing consistent benefits messaging throughout the year. We will do this through:
 - The development of a strategic custom communications plan
 - The creation of ongoing and customized communications deliverables
 - The coordination of enrollment resources
 - The utilization of vendor and technology support when available and feasible
7. **Wellbeing Solutions** – Employers want to provide wellbeing solutions which engage their employees and which ultimately impact benefits costs. CBIZ will assist the City of San Luis by:
 - Helping to develop wellbeing communication and engagement strategies
 - Providing ongoing tactical recommendations
 - Creating meaningful and sustainable wellbeing solutions using data-driven approaches
 - Monitoring and measuring results
8. **Other Services** – CBIZ will assist with:
 - The review of HRIS/electronic enrollment platform reviews and compatibility with the City's payroll system
 - Act as a liaison between other CBIZ business units which may provide needed services

Government and Public Sector Experience

CBIZ is a multi-service company providing companies with a wide variety of professional services. Both locally and nationally, we have years of experience working with many government and public sector employers and with an understanding of their unique consulting and procurement circumstances. We have assisted our clients with all their formal and informal RFPs while adhering to their procurement and purchasing requirements.

Our Arizona office currently provides Employee Benefit Consulting services to 25 public sector employers listed below, and we were recently re-awarded a five (5) year employee benefits consulting contract by the State of Arizona with this being our 2nd award of this contract. Please note that this contract also includes cooperative agreement language enabling public sector employers to 'piggyback' onto the this contract.

Government Agency Clients

▪ State of Arizona	▪ City of Tombstone
▪ Pima County Government	▪ Pascua Yaqui Tribal Government
▪ Pinal County	▪ Town of Oro Valley
▪ City of Bisbee	▪ Town of Patagonia
▪ City of Nogales	▪ Town of Prescott Valley
▪ City of South Tucson	▪ Northwest Fire District
▪ City of Surprise	▪ Picture Rocks Fire District

Public School District Clients

- Baboquivari Unified School District
- Patagonia Elementary School District
- Patagonia Union High School District
- Pima County School Superintendent
- Santa Cruz Valley Unified School District
- Santa Cruz Elementary School District
- Sunnyside Unified School District
- Tanque Verde School District
- Vail School District

Community College Client

- Eastern Arizona College

Governmental Hospital District

- Valley Wise Health Medical Center

The team we have assembled to support the prescribed Scope of Work is made up of individuals who have many years of experience working with both public sector and self-funded employers. They are experienced at working with the various stakeholders within these entities including:

- Human Resources
- Procurement/Purchasing
- Finance Staff
- City Councils
- Collective Bargaining Units
- Department Chairs
- Employee Benefits Committees
- Employee Benefits Trusts and Trustees
- External Trust Managers
- External Auditors

Our experience enables us to work effectively to assist our clients with the management of their employee benefits programs, the management of their vendors and carriers, participating with and managing employee benefits Trusts, and assisting with the development, issuance, and review of Requests for Proposals of all employee benefits related insurance coverages and services.

Those resources include local personnel experienced and versed in:

- State of Arizona procurement and purchasing policies
- Providing service to public sector employers
- Underwriting and certified actuarial services
- Analytics and reporting development and delivery
- Prior insurance carrier experience
- Prior carrier underwriting experience
- Self-funding strategy development and implementation
- Pharmacy Benefit Management
- Prior Human Resources and benefits management experience
- National and state specific employee benefits legislation and requirements

Periodic Procurement and Purchasing Training

Our staff receives periodic procurement and purchasing training from our clients, a recognized, Arizona based audit firm which specializes providing the following services to public sector entities:

- Preparation of a Comprehensive Annual Financial Report
- Audit of a Comprehensive Annual Financial Report
- Quality control review of a Comprehensive Annual Financial Report prior to submission to GFOA or ASBO
- Preparation of any additional schedules and statements included in a Comprehensive Annual Financial Report

By tapping into our client's knowledge and experience related to the auditing of Arizona based public sector employers, our team is better prepared to assist our public sector clients with the issuance, review, vetting and awarding of their employee benefits RFPs.

Public Sector Trust Experience

We currently work with several public sector, Employee/Health Benefits Trusts and have been instrumental in helping our clients to create these trusts as well. In the past, we assisted Pima County Government, Pinal County, City of Surprise and Sunnyside Unified School City with the implementation of their trusts and are currently working with the Town of Oro Valley with the implementation of their trust.

We meet regularly with each of our client's Trustees to provide them with monthly, quarterly, and annual claims and plan performance reports. We also work closely with our clients' trust administrators and finance departments with the review of their finance statements and annual audits.

Additionally, we have in-house analytics and actuarial teams which develop medical and dental insurance funding projections, reserve calculations and Incurred But Not Reported (IBNR) studies for our clients and their Trustees. We will also engage, as with our client's auditors, to provide them with any needed information.

Self-Funding Experience

CBIZ believes strongly in self-funding as an effective way for employers to have more control over their medical insurance plan strategy and as an effective way to control costs. Our belief in self-funding is evident by our Arizona office having 57 clients in alternative/self-funded arrangements. On a national basis, CBIZ has hundreds of clients also participating in these arrangements. CBIZ has invested nationally and locally in resources to support our self-funded clients.

We are proud of the service we provide our clients and evidence of their satisfaction with our services is provided in **SECTION 9** where we have included several client testimonials.

2. **Describe your approach when first working with a new client. How does this approach differ over time with clients with whom you have an established working relationship?**

New Client Onboarding

As part of our new client onboarding process, we typically meet with new clients every two (2) weeks during the first year of a new engagement. We believe that this frequency enables us to become familiar with our client's needs, goals, objectives, and benefit plans and enables our clients to get to know us better. We also typically meet quarterly with our public sector clients and their Trustees to review paid claims data and to discuss the overall performance of their employee benefits vendors and carriers. One of the quarterly meetings includes an annual Performance Review wherein we review our strategies and overall performance of our client's benefits program. We will also meet with our clients and their Trustees more often if needed.

Ongoing Service and Annual Renewals

All of our team members will be available to meet with or respond to the City's inquiries and requests. Additionally, the City's HR/Benefits staff and employees will have direct access to CBIZ's Claims Advocate for assistance with the resolution of any medical, dental or vision claims issues.

With respect to annual renewals, we like to be proactive and begin the pre-renewal process five (5) to six (6) months from the renewal date to establish a renewal timeline and to discuss plan and contribution strategies. We will also meet as needed with our clients' internal stakeholders including HR/Benefits staff, Finance staff, employee committees trusts and city councils. Our goal is to secure our clients renewals and/or to make plan or carrier changes well in advance of the renewal date to ensure timely communications with employees and to ensure timely implementation of renewals and/or plan changes.

Annual Performance Reviews and Timelines

We believe that the creation, implementation, and subsequent monitoring of an employee benefits strategy is crucial to its success. As such, CBIZ will work with the City to develop a multi-year strategy and will revisit that strategy with the City annually. During our annual meeting, we will review changes in the strategy, the implementation of new plans, programs, vendors, and carriers and will measure the effectiveness of those changes.

We will also discuss the implementation of approved strategies which have not yet been implemented and will discuss any new strategies, programs or plans which could benefit the City and/or its employees.

We couple the strategy document with an annual service and review timeline to ensure timeliness in the decision-making process and implementation of any changes or new programs, plans or services. We are keenly aware of the decision-making layers within an entity such as the City of San Luis, so we will work closely to ensure that all decisions are made and presented on a timely basis.

Please refer to **SECTION 3** for a sample Annual Performance Review document and sample Renewal and Service timeline.

3. **Please give a high-level overview, methodology or work plan of how your company would assist the City in developing its overall employee insurance benefits strategy.**

Strategic Planning

Strategic planning is an important part of our client partnerships, and developing a well-documented strategy is the blueprint for success. Typically for a new engagement, CBIZ will work closely with your Human Resources and Finance teams to document a three (3) to five (5) year strategy. Our focus is to help you align your employee benefits program with organizational goals, annual budgets, legislative mandates, obtaining the best pricing, manage compliance liability, and maximize employee satisfaction.

Employee benefits are a substantial investment affecting multiple facets of your business, from organization morale and employee retention to administrative efficiency and your bottom line. That is why CBIZ begins each engagement with an understanding of its Benefits and Human Resources objectives to ensure that your benefit initiatives support your organization's business and financial objectives. Rather than supply packaged solutions, we will collaborate with you to develop a customized action plan to achieve the goals you set.

Based on our planning sessions, we will create an action plan that will include and address the following:

- A description of current benefit plans and actions to align benefits with your organization's needs, goals, and objectives.
- A review of your historical costs and current costs.
- A review of your historical strategies, your defined future strategies, and an assessment of the success

of your strategies.

- Your claims costs and other cost liabilities and how they align with your budgetary goals.
- Your employee recruitment and retention strategies and how to enhance them.
- Proposed services including potential renewals and marketing, funding analysis, health and productivity initiatives, communications practices, compliance activities, enrollment maximization, etc.
- The development of a future timeline showing milestone activities, responsibilities, and completion dates.

Setting Short-Term & Long-Term Goals and Objectives

Together, we will explore City of San Luis's:

- Organizational and business objectives
- Financial objectives and budget constraints
- Total compensation and benefits philosophy
- Employee demographics and expectations
- City Council's, senior management's and HR/Benefits' concerns
- Short-term and long-term initiatives

During our planning sessions, we will listen, ask questions, and provide insights. The outcome will be well defined goals and objectives for benefits in the upcoming year and beyond. We will collaborate with you to develop a customized action plan. Each of our clients receives an Annual Performance Review (Stewardship Report) which reviews, assesses, measures and reports on the prior plan year's performance, goals and objectives and is used to develop future years' strategies and initiatives.

4. **Describe the methods your firm uses to evaluate healthcare carriers when determining those that would be suitable for providing the services and pricing required by your clients. Also, based on what you may know about the City, are there specific carriers to whom you would market the City's healthcare insurance requirements?**

As one of the state's largest employee benefits consulting firms and with over 400 group clients in Arizona, we work with a wide range of carriers and vendors. Locally, we are regularly sought out by carriers and vendors to provide us with presentations on their products and services. On a national level, our **Health Innovations Practice** meets with innovation driven vendors and carriers regularly to vet out their services and products and to create a list of 'approved' vendors and carriers for our clients.

Rather than make specific carrier recommendations at this time, we would prefer to share some proven strategies for your consideration. If we are to be retained as the City's consultants, we will work closely to gain a complete understanding of your needs, goals, and objectives and to work with you to create a strategy which will meet your needs, goals, and objectives and to seek vendors and carriers that will fit into a long-term strategy.

Strategies for Consideration

As City of San Luis's consultants, we will seek to find cost savings and benefit improvement solution through the following approaches:

Funding Strategies

We commend City of San Luis for already being self-funded. As City of San Luis's consultant, we will conduct an in-depth, actuarial assessment of the City's claims performance and evaluate its reserves position to ensure that its plan is viable and solvent. We will also conduct annual assessments (aka Monte Carlo modeling) of City of San Luis's stop-loss insurance levels to ensure that they are adequate and will make recommendations on possible increases to them. Additionally, we will use our actuarial tools to provide City of San Luis with plan change modeling including the potential cost savings associated with those changes.

Marketplace Reviews

We encourage our self-funded clients to conduct, at a minimum, a TPA, PBM and stop-loss insurance marketplace evaluation at least every three (3) years and to evaluate their ancillary coverages at each contract renewal. And in the event that City of San Luis elects to conduct a marketplace review CBIZ will:

1. Work with City of San Luis's human resources and procurement departments to develop RFPs
2. Assist with the distribution of RFPs
3. Assist with the review, analysis and scoring of RFP responses
4. As needed or requested, work with other departments and applicable employee benefits committees
5. Be fully involved with the implementation of any carrier/vendor changes

Pharmacy Purchasing Coalitions

These coalitions are comprised of member companies with a culmination of hundreds of thousands of covered lives. Through the buying power that these coalitions provide, we are able to minimize the expense of prescription drugs through mass purchasing and through maximized drug manufacturer rebates to our clients. By placing our clients in these coalitions, we have been able to save our clients millions of dollars on their prescription drug expenses.

Pharmacy Assistance Programs

These programs take advantage of philanthropic programs which assist in paying for the entire cost of costly, prescription medications. By removing these expenses from an employer's plan, they avoid paying the cost of the medication, the employee is not subject to any out-of-pocket expenses and CBIZ is able to negotiate better stop-loss insurance rates and in some cases to avoid the assignment of lapsed claims by stop-loss insurance carriers.

Stop-loss Insurance Captives

A captive insurance company (referred to simply as a 'captive') is an insurance company that is set up and wholly owned by a non-insurance company to act as a direct insurer or reinsurer for the parent company and its subsidiaries. The primary purpose of a captive is to reduce the company's total cost of risk. Captives are often used as an integral part of a company's international insurance program but can also cover local risks or be used in a purely domestic structure.

CBIZ has begun to provide our clients with captive strategies to lower their premiums while spreading risk among their captive members. CBIZ would work with the City to determine if a captive stop-loss insurance arrangement would be in its best interest.

Onsite or Near-Site Clinic Consulting

CBIZ's Clinical Consulting Practice has experience and serves clients nationally. Our team is led by Erin Eason, National Director of Clinical Consulting. Erin has worked with over 40 clients on over 100 projects ranging from the initial determination of feasibility to vendor selection, implementation as well as ongoing consulting. We leverage our broad client and vendor experiences to formulate initiatives that drive meaningful outcomes that lower the cost of health care for both our clients and their employees, improve access to care and improve metrics like employee absenteeism, employee satisfaction and disability claims.

Provider Direct Contracting

CBIZ has successfully worked with medical care providers which are interested in providing our clients with better access to care at discounted rates (below provider network negotiated discounts).

Reference Based Pricing Programs

These programs work to lower the cost of care provided by hospitals and outpatient facilities by setting the cost of care at a percentage above Medicare's reimbursement schedules, e.g., 150% above Medicare. These programs quickly drive down the overall cost of care being provided at those types of facilities while providing employees the ability to access providers across the country. These programs also include protections for employees to guard from "balance billing" for the cost of care that is billed above the paid amounts.

Case Rate Payment Programs

These programs provide pre-negotiated 'case rates' for specified treatments at contracted medical providers. Some of these treatments could include dialysis treatments, organ transplant services and orthopedic services. The vendors fully vet the providers, and these programs drive costs down and remove any balance billing surprises that can happen under traditional, network contracted arrangements.

Directed Care & Population Management Solutions

These programs help employers to provide care to their employees:

- At best-in-class facilities which may include domestic medical tourism;
- Through care management models;
- Through provider and member care engagement practices;
- With second opinion services to ensure the proper levels and types of care.

These programs help to improve outcomes of care and can lower the overall cost of care.

5. **Aside from pricing, what criteria do you recommend that your clients should use in evaluating and selecting specific insurance carriers?**

Below are the top criteria we recommend when evaluating insurance carriers:

■ Experience working with public sector entities with an understanding of their needs and challenges	■ Online enrollment and billing capabilities
■ Longevity in the market	■ A willingness to openly engage with brokers and consultants
■ Proven ability to deliver service	■ A willingness to invest in long-term strategies
■ Proven desire and ability to innovate	■ Ability to be transparent in its dealings with our clients
■ Ability to be flexible when needed	
■ A robust and responsive customer service infrastructure	

6. **What is your process for reviewing a client's existing benefits programs and determining whether to make recommendations for changes in carriers, benefits offered, funding strategies or other changes to the total benefits package of products and services?**

When CBIZ takes on a new client we work closely with them and their carrier and vendor partners to obtain all pertinent plan information including:

- Plan design information on all lines of coverage
- Plan documents and contracts
- Current rates and contribution strategies
- Analytic and actuarial analyses for current plan year and for prior two (2) plan years
- Three (3) years of past renewals
- Year-to-date and two (2) prior years claims data
- Copies of employee benefits communications
- Copies of wellness/wellbeing program information
- Two (2) years of Employee Benefits Trust agenda and meeting minutes
- Historical renewal timelines and future renewal timelines

Also, because CBIZ offers consulting services that extend beyond benefits, we are sometimes able to identify other human resources related needs that can be addressed by utilizing CBIZ's other internal partners.

7. How many clients do you service in the 250-500 covered lives range?

Below is a breakdown of our clients with over 100 employees:

- 100 to 249 employees – 25 clients
- **250 to 500 employees – 15 clients**
- 500 – 40,000 employees – 19 clients

a. Which, if any of these, are governmental entities?

We provide service to 25 governmental entities, with 6 of them being in the 250 to 500 employee range.

b. What are the specific employee benefits issues that are faced by organizations in this size range in today's benefits market?

Cost control is the overriding challenge that employers such as the City of San Luis face. This affects their ability to offer competitive benefits which attract and retain employees. Below are several areas of concern which CBIZ is experienced at addressing for similar-sized employers.

Budgetary & Employee Recruitment and Retention Challenges

As the cost of benefits continue to rise, it is important for employers to find the most cost-effective ways to minimize increases in costs. These strategies must be well planned and executed to ensure that they not only achieve the employer's budgetary objectives, but that they also meet the organization's recruitment and retention objectives. A competitive employment market makes it more important for employers to offer competitively priced benefits and to be able to effectively communicate the value of those benefits to new recruits and to existing employees. Additionally, government entity employers have seen a higher-than-normal level of retirees and have been lagging in replacing open positions. We will work closely with the City of San Luis to craft strategies to meet its goals and objectives.

Alternative/Self-Funding Opportunities

Our experience working with employers of the City of San Luis's size have shown us that these employers have a good opportunity to control their medical insurance costs through the right mixture of alternative funding strategies and components. The challenge for many employers, however, is fully realizing how the right components can work to minimize costs. CBIZ is adept at providing our new clients with retrospective reviews of their claims' liability coupled with prospective analysis to identify cost savings opportunities.

Because the City is already offering a self-funded medical insurance program, there are a

variety of cost savings strategies that CBIZ can help the City to explore. More information on these strategies will be provided later in CBIZ's response.

Communications Challenges & Opportunities

We have found that employers with employees in multiple locations and working on 24-hour shifts tend to be challenged with how to effectively communicate the value of their benefits package to their employees. Employers such as the City of San Luis need to regularly explore the best ways to effectively communicate to their employees and to be able to do so across a variety of platforms. CBIZ is experienced in helping our clients to find the best and most effective methods of communication and how to apply those.

Wellbeing and Wellness Challenges & Opportunities

Wellbeing and wellness have become an especially vital component of employers' employee benefits portfolios and if done properly, can have a profound impact on the cost of healthcare within an organization. Effective communications of wellbeing programs can be fairly challenging along with creating sustainable, long-term, and measurable wellness programs. CBIZ has found that by working closely with our clients to identify their wellness goals and objectives through a cultural analysis of the organization and our in-house Engagement and Wellbeing helps them to craft more effective and sustainable wellbeing programs.

8. Provide examples of the employee communications materials you provide, if any.

Benefit Education & Communication Services

One of the hallmarks of the services that our Arizona office provide our clients is ***in-house professionally developed and customized communications and education materials***. We will work with City of San Luis to improve employee engagement by providing consistent benefits messaging throughout the year. We will do this through:

- The development of a strategic custom communications plan
- The coordination of enrollment resources
- The creation of ongoing and customized communications deliverables
- The utilization of vendor and technology support when available and feasible

The monetary, equivalent value of these professionally developed services, if obtained through a third-party vendor, can easily exceed \$25K in cost but CBIZ understands how valuable they are for our clients and includes most of them in our standard Scope of Services.

Effective Employee Communications Strategies

You have a significant investment in your employee benefits program and CBIZ wants to make sure that you are getting the best return on your investment. Clear, effective communication is the key to success for any employee benefit plan. Health plans, in particular, are expensive programs that require employee decision-making, so it's essential to give employees the information **and** tools they need to enroll and make the most of the program. Employers such as City of San Luis need to regularly explore the best ways to effectively communicate to their employees and to be able to do so across a variety of platforms.

Examples of some of the communications support services are provided below.

Please refer to **SECTION 3**, for Communications Documents Samples.

Technology Solutions: Flipping Book

In addition to the Access platform, CBIZ can utilize a software known as FlippingBook. This interactive online publishing site transforms files into digital, interactive online publications and can be used for employee communication and education. Sample FlippingBook Projects include:

- Employee benefit guides
- Benefits highlight brochures
- Open enrollment materials
- HR/New hire handbook



A sample of Sunnyside Unified School District's 2023/2024 benefits bookshelf can be accessed by clicking on the UR code here. Within the document you will be able to access benefits documents by clicking on the icons on the bookshelf; the following items are accessible:

- The 2023/2024 Annual Enrollment voice-over video outlining the benefits being offered
- A Benefits Guide in Spanish
- A Benefits Guide in English
- An HSA resources document
- An FSA resourced document
- A Decision Doc flyer in Spanish with a QR code
- A Decision Doc flyer in English with a QR code

Communication Media and Materials

CBIZ offers a range of communication services, from basic enrollment support to customized communication campaigns. Materials and media may include:

- Web blast announcements;
- Online summaries, benefits guides, links to carrier sites, and benefit bulletins;
- Subscription to Brainshark

CBIZ's Communications Development Process

Following best-practice communication principles, we will:

- Understand the audience, complete analysis of City of San Luis's population;
- Clearly define communication objectives, activities and materials, responsibilities, deadlines, and costs;
- Link employee needs and expectations to organizational goals and financial realities;
- Use clear, concise, and actionable language;
- Use a variety of media to reinforce key messages and accommodate different learning styles;
- Provide simple tools such as examples and worksheets to help employees make critical decisions;
- Consider variations in employee technical knowledge and;
- Solicit feedback on communications and make adjustments as needed.

Communication Examples

Brainshark Videos

CBIZ has partnered with Brainshark, a leading cloud-based platform for employer and employee education. Presentations can be viewed on- demand at the audience's convenience, "anytime, anywhere," including on mobile devices. Employees can review benefits communications as often as needed and easily share with others in their household.

CBIZ is able to script and produce these voice over benefits presentations to be given at large group meetings and posted on City of San Luis's intranet for 24/7 access. This tool has been used by CBIZ clients for the following:

- Educate employees on understanding their benefits and becoming better consumers
- Teach the basics of HDHP and HSA programs
- Explain how to use new or existing benefit enrollment solutions
- Introduce new wellness programs
- Explain the benefit program to new and existing employees

Improved productivity: Employees receive training and communications on topics such as open enrollment, new hire onboarding, wellbeing, and important legislative updates, while minimizing non-productive time. Uniform messaging: Consistency and clarity are critical when delivering an effective message. Employees will be able to view the same message and retrieve all the necessary forms to make informed decisions.

This technology has been instrumental in engaging employees and has been utilized by many of our clients. *An example of a recent Brainshark video can be found by scanning the QR code:*



CBIZ will provide communication development and distribution for all standard communication materials as part of the standard scope of services and will provide these materials in Spanish as well if needed.

9. Describe your ability and experience with

a. Self-funded insurance plans.

At CBIZ, we have been implementing self-funding strategies with our clients for over 30 years. We presently have 57 local clients in self-funded arrangements, and hundreds of them throughout the CBIZ enterprise. We support our clients' self-funding strategies in the following ways:

- We are one of the largest, self-funding consulting agencies in Arizona and are experienced and adept at implementing and managing self-funded strategies.
- We employ a local team of reporting analysts supported by in-house, **certified** actuaries which provide our clients with comprehensive reporting, cost, and funding projections, IBNR studies and reserve setting calculations.
- We have an in-house Pharmacy Benefits Consulting practice. This enables us to find optimal pharmacy benefit management programs based on our clients' specific prescription drug claims utilization.
- We have an in-house ERISA trained legal team supporting our self-funded strategies. These resources enable us to provide compliant consulting to our clients.
- Our employees receive ongoing training on self-funding strategies, programs, stop-loss insurance, and pharmacy benefit management to remain informed on most current strategies and services available and how to assist our clients with the assessment and implementation of these strategies and services.

Additionally, we have an in-house *Health Innovations Practice* that works to identify and to vet out companies which can provide our self-funded clients with creative and innovative approaches, strategies, and resources and which can provide our clients and their employees with meaningful results – *some of the strategies we have assisted our clients with implementing are showcased in the client Case Studies provided in SECTION 8.*

b. Plans offering coverage in Mexico.

We have been working with Mexico plans since 2017 and are familiar with the functionality of these programs. Our client, the City of Nogales Employee Benefits Trust offers International Medical Solutions' (IMS) Mexico

plan and the City of Nogales, and its employees have been pleased with the services and continued expansion of services IMS provides along with the beneficial cost impact to the Trust. Additionally, we were instrumental in working with the largest public school district trust in Arizona, the Arizona School Boards Association Insurance Trust (ASBAIT) with offering International Medical Solutions to its 115 member districts.

*Please note: In **SECTION 3, Work Samples: Claims Reporting & Financial Documents Samples**, we have provided a report for one of our clients which offers a Mexico plan. Within that report, you will see how we separate and report the Mexico network's claims costs.*

10. Describe your firm's experience in securing, monitoring, and evaluating third party claims administrators on behalf of your clients?

Our 30 plus years of experience in creating and implementing self-funded insurance strategies enables us to provide our clients with a wide breadth of knowledge with these strategies. Both locally and nationally, we work with a wide variety of Third-Party Administrators, Provider Networks, Stop-loss insurance carriers and Pharmacy Benefit Managers to ensure that our clients have the most cost-effective partnerships in place.

We utilize a variety of tools to secure, monitor and evaluate claims on behalf of our clients. These include the production of claims reports through our in-house Analytics and Actuarial teams. We also utilize a third-party claim reporting and analytics platform called **Innovu** to monitor and track a variety of claims payment and utilization points including duplicate billing, excessive payments, use of prior authorization and other point solutions. We utilize this data to hold the administrators accountable and use this data to negotiate the best rates and fees possible for our clients.

Additionally, because of our reputation as a pro self-funding brokerage, we have developed solid relationships with many Third-Party Administrators, stop-loss insurance carriers and Pharmacy Benefit Managers both locally and nationally; this translates into better service outcomes for our clients.

Please refer to **SECTION 3** for claims and financial reports samples.

11. Demonstrate your ability to tailor plans for an organization based on available funds and programs related to employee needs.

We work closely and systematically with our clients to understand their needs, goals, objectives, and challenges. When evaluating our clients' employee benefits programs, the two most critical areas are, 1) costs and ability to fund those costs by both the employer and employees, and 2) employees' needs.

With our self-funded clients, we have more latitude to create programs which can address both of those areas effectively. Our experience with our clients has taught us that offering rich and affordable employee benefits programs are key to both their recruiting and employee retention efforts.

Because of budgetary limitations that many public sector employers face, we work closely with our clients to understand their budgetary abilities and goals and to continue to assist them in meeting those goals while keeping their employee benefits attractive and affordable for their employees. Since there are many areas that can factor into the cost of an employee benefits program, and particularly so with the medical insurance plan, CBIZ continually seeks innovative approaches which can help to mitigate costs.

Although low costs are key, we never lose sight of the impact of costs, plan designs, and types of employee benefits plans offered and how they affect our clients' employees and family members.

We are also experienced at working with many key stakeholders including:

- Sr. Administration Teams
- City Councils
- Human Resources and Benefits Teams

- Employee Benefits Committees
- Bargaining Unit Employees
- Benefits Trustees
- Procurement and Purchasing Departments

As you will learn below and through the case studies we have provided in **SECTION 8**, you will learn how we utilize a variety of strategies to ensure that our clients are receiving the best possible pricing. Additionally, as one of the largest employee benefits consulting agencies in Arizona and nationally, we are able to leverage our size and experience to provide our clients with the best pricing possible.

12. Demonstrate your ability to tailor innovative plans and how this might help manage overall long-term health costs?

As mentioned previously, we have an in-house **Health Innovations Practice** that works to identify and to vet out vendors and carriers which can provide our self-funded clients with creative and innovative approaches, strategies, and resources and which can provide our clients and their employees with meaningful results. We have successfully utilized a wide range of vendor and carrier resources to develop long-term and meaningful cost-saving strategies.

In **SECTION 8**, we have provided several **Case Study** examples of innovative approaches that we have implemented to save our clients millions of dollars.

Thought Leadership Resources

In addition to providing our clients with tailor made, innovative solutions, CBIZ also offers our clients a variety of thought leadership resources along with educational opportunities through webinars and published articles and newsletters. Our clients have access to the following types of educational opportunities and thought leadership resources:



2023 State of Health Care Guide: Large Employer Strategies to Combat Rising Costs

A guide offering strategies to help combat rising health care costs as you manage the bottom line with insight on rising costs and premiums, the high deductible gap, functionally uninsured populations and why health care costs are resistant to intervention. We will demonstrate how you have more control than you might think in promoting positive change in employees' health care experiences.



You can access the guide by scanning the QR code.



Regulatory & Legislative Update: What Employers Need to Know in 2023

This update recaps what happened in 2022 and what is important to know in 2023 regarding the year's legislative, regulatory, and associated developments, including ACA Matters and benefit-related cost-of-living adjustments. See answers to CBIZ's top three most-asked benefits questions: Who is eligible for my plan? When does eligibility end? When must claims be submitted?



You can access the document by scanning the QR code.



CBIZ Open Enrollment Success Guide

Using a digital-forward approach, this guide shows you how to boost engagement for open enrollment while alleviating complexity. Learn the best practices, checklists and

strategies needed for effective administration and communication of open enrollment. See how a customized high-tech, high-touch digital strategy increases effectiveness and efficiency while decreasing the burden on HR teams.

13. Explain what resources/methods you use for pharmacy cost control?

Because of the many complexities surrounding the cost of drugs and the administration of pharmacy benefits by Pharmacy Benefit Managers, it is vitally important for our self-funded clients receive in-depth and objective analysis of their pharmacy costs. As such, CBIZ created an in-house Pharmacy Benefits Consulting practice 10 years ago and the services they provide have proven to be financially beneficial to our clients and their employees.

Our Pharmacy Benefits Consulting practice consists of four (4) individuals familiar and experienced working with Pharmacy Benefit Managers and pharmacy benefit coalitions. Our Pharmacy Benefits Consulting practice is led by pharmacist, Michael Zucarelli, who has been working in the employee benefits field for over 10 years. Our team members are versed in all available forms of PBM models and practices and work to find best-in-class and best-in-cost PBM solutions for our clients.

Our team provides the following consulting services:

- In-depth review of PBM contracts
- In-depth review of PBM formularies
- In-depth review of claims utilization
- Comprehensive reviews of PBM's net costs including applicable fees and rebates
- Comprehensive comparisons of stand-alone PBMs and PBM coalitions
- Review of a pharmacy Patient Assistance Programs and their positive financial impacts on our clients and their employees
- Conducting of comprehensive formulary disruption analyses when PBM changes are being considered
- Collaboration with CBIZ's service and analytics/actuarial teams
- Assistance with the negotiations of stop-loss renewal contracts affected by the implementation of cost-saving pharmacy programs

14. Describe your capacity, ability, and experience offering employee wellness programs to promote healthy lifestyles and reduce exposure to long term health costs.

Under our scope service, we will also provide the City with access to our **Engagement and Wellbeing** team including our Arizona Based Engagement and Wellbeing Account Executive, Anisa Karczynski.

CBIZ is a national leader in developing and implementing award winning population health management programs including wellness, health and productivity and wellbeing strategies. Wellbeing evolves from wellness and includes physical, financial, social, community and career health. We will provide specific guidance to capitalize on the existing wellness program and create a sustainable culture of health.

Our CBIZ Wellbeing Solutions team uses an integrated approach that moves beyond the measurement of physical wellness to include a holistic wellbeing strategy of social, physical, financial, career and community health. Our Arizona based Engagement and Wellbeing Account Executive, Anisa Karczynski will develop metrics using actionable data to measure awareness, engagement, participation, and employee satisfaction in all wellbeing initiatives. Our customized solutions include a variety of data-driven assessments and analysis, evidence-based interventions, practical tools, and empirical measurement to deliver results. Our wellbeing team represents the culmination of more than 20 years of experience working with some of the most innovative and expert minds within the health-improvement arena.

Upon being hired by the City, our **Engagement and Wellbeing** team will work with the City's staff to:

- Assess your current wellbeing strategies and programs and learn about the history of your program
- Assess and challenges and discuss opportunities for change or improvement
- Engage with your wellbeing committee to discuss its goals and objectives
- Engage with the City's wellbeing vendor

- Explore any wellbeing programs offered by the City's Third-Party Administrator
- Determine if there is a need to develop and issue a culture survey to assess employees' benefits and cultural needs and wants
- Determine if there is a need to issue an RFP for a wellness vendor
- Assess your Employee Assistant Program (EAP) and review utilization of the plan
- Determine if there is a need to issue an RFP for an EAP vendor

Wellness Vendor Management

CBIZ's Wellbeing Solutions team provides expert consulting to our clients that includes marketing, evaluating, and facilitating the selection of a third-party wellbeing vendor. Our consultants assess the client's needs and then manage the entire vendor RFP process. CBIZ has vetted more than 100 wellbeing providers, resulting in knowledge and experience with best-in-class vendors, and proven success in achieving results for clients. Our team will help the City to identify potential wellbeing vendor partners and conduct analysis including vendor RFPs for services including but not limited to: Employee Assistance Programs, financial wellness programming, health risk assessments, incentive design, and biometric screenings.

15. Other than the lines of coverage specified in this RFP, describe other lines of coverage for which your firm has expertise.

We provide consultation and services for the following lines of coverage:

■ Worker's compensation	■ Individual wealth management services
■ Property and Casualty insurance	■ Individual life and disability insurance
■ Errors and omissions insurance	■ Individual medical, dental & vision insurance
■ Officers and Directors liability insurance	■ Service bonds
■ Medicare Advantage and supplements	
■ Group retirement plan services	

Please note that service for the above lines of coverage are not included in our scope of services or fees but can be made available to the City or its employees upon request and with separate fees and/or paid commissions.

16. What special capabilities or attributes does your firm have that makes your firm the best choice for the City of San Luis?

The CBIZ Difference – What Sets CBIZ Apart From Our Competition?

We know the City has options when it comes to choosing an employee benefits consultant. While any broker can run the numbers and market your plans, it takes an innovative partner to execute a collaborative strategy.

1. **Our biggest difference from our competitors is our people.** We bring passion, purpose, and innovation to everything we do. We view ourselves as a strategic and trusted partner and an extension of the City of San Luis's benefits and HR departments. This translates to strategies that are meaningful and impactful to the City and will result in long-term success. We take the time to understand the unique needs of your business and your people and base our solutions on these qualities. We will not offer canned solutions that do not take the City's culture into account. We believe this comprehensive approach is integral to building better benefit plans that lead to improved understanding and compliance, creating a culture of healthier, happier employees.
2. **We are experienced at working with government and public sector employers.** Our many years of experience working with a wide variety of public sector employers makes us a perfect fit for the City of San Luis. We understand your needs and your challenges and know how to provide you with the type of service and effective strategic consultation that you need.

3. **We are a full-service agency and are uncompromising in the delivery of service.** We are committed to meeting the City's needs, goals, and objectives and towards expending the effort needed to meet those. We will commit to providing you with timely service and to bringing the City effective and measurable ideas and strategies.
4. **We are uncompromising in our desire to discover and test next practices, ensuring we are bringing more than just the placement of insurance products.** Our consultative approach incorporates both the cost and the employee impact when presenting solutions. We bring thought leadership and proven solutions so the City has confidence that programs and strategies that are designed are best in class.
5. **We are consultative** - We are product and vendor agnostic. We research, vet, and partner with many vendors that provide the best fit for our clients' varying needs.
6. **We are recognized as an industry leader and a top firm** – We are regularly recognized as an innovative and service leading consulting firm by a variety of national rating firms. Additionally, we have established ourselves, both locally and nationally as a top consulting partner by insurance carriers, Pharmacy Benefit Managers, and benefits vendors. On a local basis, we are considered a top five (5) broker and are regularly consulted by a variety of carriers regarding marketplace trends, plan design development and for our actuarial and analytic expertise.

We genuinely believe that the resources and expertise we can provide to the City of San Luis will enable it to meet and exceed its employee benefits and financial goals and welcome the opportunity to work with the City, its Trustees, and its employees

17. **Provide three (3) reference names and contact telephone numbers for other current clients in the general size range of the City, whom we may contact.**

References are provided in **SECTION 2** of the response. If the City would like additional references, CBIZ is happy to provide them.



SECTION 6

SCOPE OF WORK (EXHIBIT B)

EXHIBIT B – SCOPE OF WORK

I. Project Overview

The City seeks statement of qualifications/proposals from experienced and qualified firms to provide broker-of-record and consulting services for the City's employee benefits programs.

II. Scope of Services

The City seeks qualifications from experienced, compliant with applicable and licensing for the profession, and otherwise qualified firms to provide broker-of-record and consulting services for the City's employee benefits programs including, but not limited to, the City's following programs:

- Health Insurance (*US/Mexico Plan & Mexico Only Plan*)
- Voluntary Dental Insurance (*US/Mexico Plan & Mexico Only Plan*)
- Voluntary Vision Insurance
- Life and Accidental Death & Dismemberment (AD&D) Insurance
- Short-Term and Long
- Section 125 Flexible Spending Accounts
- COBRA - third party administration
- FMLA administration
- Wellness Plan
- Telemedicine
- Employee Assistance Program
- Voluntary Supplemental coverage
- Stop Loss Insurance
- Other Ancillary Benefits as Deemed Appropriate

The broker/consultant selected will provide a full range of consulting and brokerage services in cooperation with the City staff and management. The broker/consultant will assist the City, by performing a full range of services related to the design, implementation, maintenance, communication, and improvement of the City of San Luis group medical, dental, vision, STD/LTD, life insurance coverage and other various benefits as listed above. The broker/consultant will be expected to provide services including, but not limited to, the following:

ADMINISTERING ALL GROUP INSURANCE PLANS, RESPONDING TO QUESTIONS FROM AND PROVIDING INFORMATION TO STAFF, AND PROVIDING OTHER CONSULTING SERVICES DURING THE COURSE OF THE PLAN YEAR.

CBIZ will assemble a team of professionals which will be responsible for providing timely service to the City's staff. Our commitment will be to respond to all inquiries within 24 hours of receipt of the questions, issues, requests for guidance or requests for clarifications.

REVIEWING CLAIMS EXPERIENCE, CLAIM SERVICE, AND CLAIM ADMINISTRATION TO ENSURE MAXIMUM BENEFIT TO THE CITY.

CBIZ believes in tracking, obtaining, and sharing claims performance data with our client so that our clients are regularly aware of how their plans are performing and to help to avoid any renewal surprises. With this in mind, CBIZ created an in-house data analytics and actuarial team to assist us

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in providing detailed claims and administrative cost reporting to our clients.

CBIZ's service and analytics teams will work closely with the City of San Luis's Third-Party Administrator and insurance carriers to obtain claims payment reporting. CBIZ will review the data and will create customized reporting for the City of San Luis. The frequency of the reporting will be determined by the carrier so CBIZ will work to obtain that data when it becomes available.

The reporting and financial support that we will provide the City will include:

Comprehensive & Detailed Monthly Claims/Cost Performance Reports

These reports will provide the City of San Luis with a fully transparent method of tracking their ongoing monthly and projected annual claims and administrative costs performance. This report is a valuable resource when tracking costs throughout the plan year as well as useful in predicting how current and projected future claims costs will affect renewals.

The monthly reports provide and track the following data:

- Headcounts by plan
- Paid medical and Rx claims by plan
- Administration and stop-loss insurance fees and rates
- Employer HSA contributions
- Stop-loss reimbursements if and when applicable
- Prescription rebates when received
- Provide a loss ratio calculation and comparison against budgets and/or reserves
- Report any funding surpluses or deficits
- Provide Per Employee Per Month costs
- Track year-over-year costs on a gross cost and Per Employee Per Month basis
- Provide large claimant reports and track changes in the large claimants' costs monthly to determine increases/decreases in costs, projected ongoing or future costs – this tracking is important to know especially during the renewal process

Annual Medical & Dental Plan Renewal Projections and Reporting

- CBIZ will incorporate its monthly claims reporting into the City's annual renewal and Funding Projections. CBIZ uses a sound and proven actuarial approach utilizing national market trends as well as historical and current and projected claims costs in its Funding Projections and will provide the City with a variety of funding options.
- CBIZ uses our calculations to validate the insurance carriers' projections and will use our calculations to negotiate the best possible renewals on the City's behalf.
- CBIZ will periodically produce a 'Monte Carlo' stop-loss and benefit level analyses to ensure that the City's stop-loss insurance levels are set appropriately. Along with the Monte Carlo study, CBIZ is also able to provide the City with plan cost modeling & impacts on plan changes.
- CBIZ will provide the City with quarterly Incurred But Not Reported (IBNR) cost estimates to use in tracking the City's reserves.
- CBIZ will provide the City with contribution strategies that align with the City's contribution and budget goals.
- 60 to 90 days following the City's renewal, CBIZ will create and provide the City with a Premium Adequacy Report which is a recalculation of the renewal Funding Projections. This report utilizes a full year's worth of claims and administration/stop-loss costs and considers any plan changes and migration that may have occurred during the annual enrollment period. This report ensures that the City's reserve calculations used in the renewal Funding Projections continue to be adequate.

Other Reporting

- CBIZ will also provide the City with semi-annual claims, cost avoidance and gap-in-care analytics reports through the *Innovu* platform.
- And as needed, CBIZ will work with the City's Third-Party Administrator to create ad-hoc, drill down reports to

track and investigate any outlier or trending claims costs.

- CBIZ will also work annually with the City's Third-Party Administrator to provide the City with an annual, retrospective claims and plan performance report.

DETERMINING AND RECOMMENDING THE MOST ECONOMICAL FUNDING METHODS FOR THE BENEFIT PROGRAMS.

CBIZ will work with the City and its vendor and carrier partners to obtain the most economical funding methods and pricing for its benefits programs. CBIZ will also work with the City to develop, issue and review Requests for Proposals for all lines of insurance coverage as needed.

REPRESENTING THE CITY IN ALL NEGOTIATIONS WITH PROVIDERS ON ALL ISSUES INCLUDING THOSE RELATED TO PREMIUMS, BENEFIT LEVELS, PLAN DESIGN, AND SPECIAL TERMS AND CONDITIONS.

CBIZ will act in the City's best interest when negotiating on its behalf and will work to ensure that the City is always receiving the best and most fair pricing available. CBIZ will also work closely with the City to determine the best benefits and plan design needed for the recruitment and retention of its employees.

MEETING WITH AND PROVIDING REPORTS TO VARIOUS CITY REPRESENTATIVES INCLUDING THE CITY MANAGER, HUMAN RESOURCES DIRECTOR, FINANCE DIRECTOR, AND EMPLOYEE BENEFITS TRUST.

CBIZ will be available to meet with any of the City's designated representatives, entities and stakeholders as needed.

RECOMMENDING ITEMS TO BRING TO THE BOARD OF TRUSTEES' MEETINGS SUCH AS ADDING OR CHANGING PROGRAMS, TRENDS IN CLAIMS. THE BOARD MEETS AT LEAST FOUR TIMES PER YEAR FOR STAFF TO REPORT ON THE TRUST FUND BALANCE AND OTHER TOPICS THE BROKER/CONSULTANT MAY PRESENT AFTER CONSULTATION WITH STAFF. IT IS EXPECTED BROKER/CONSULTANT COMPLY WITH THE BOARD'S DEADLINES, ATTEND TRUST MEETINGS AS NEEDED, AND ADHERE TO THE OPEN MEETING LAW AND BASIC ROBERT'S RULES OF CONDUCT DURING BOARD MEETINGS.

CBIZ will be available to meet with any of the City's Trustees as needed and will work with the City to develop Trust agenda items and topics including claims reporting and plan performance reporting, industry trends affecting the City and Trust. CBIZ agrees to meet all prescribed deadlines and to abide by the City's and Trust's meeting law requirements.

ATTENDING THE CITY COUNCIL'S ANNUAL BUDGET MEETING IN APRIL TO EXPLAIN THE UPCOMING PLAN AND FUNDING NEEDED FOR THE PLAN WHICH STARTS ON JULY 1.

CBIZ agrees to attend and present any materials related to plan renewals and funding projections.

IMPLEMENTATION AND FOR THE EMPLOYEES' COMMUNICATION OF NEW PROGRAMS OR CHANGES TO EXISTING PROGRAMS (WRITTEN MATERIAL IN ENGLISH & SPANISH), THAT WILL INCLUDE ATTENDING AND PRESENTING INFORMATION AT OPEN ENROLLMENT MEETINGS.

CBIZ will work with the City to provide any needed benefits related communication requested and will work with the City to enhance any current communications materials or processes to best meet its employees' needs. CBIZ further agrees to provide this information and collateral in both English and Spanish.

RESEARCHING AND ADVISING THE CITY OF ANY NEW DEVELOPMENTS IN THE STATE AND FEDERAL LAW AND EMPLOYEE BENEFIT PROGRAMS ON AN ONGOING BASIS.

CBIZ will provide the City with updates on any benefits related, legislative changes which may affect the City's employee benefits programs. CBIZ has an in-house legislation team which will provide the City with periodic communications about proposed or passed legislation. This will come in the form of memos, newsletters, seminars, webinars, and checklists.

PROVIDING TIMELY COMPLIANCE WITH STATE AND FEDERAL LAWS AND REGULATIONS EXISTING AND AS AMENDMENTS BECOME EFFECTIVE RELATED TO EMPLOYEE BENEFITS AND TO SELF-FUNDED GROUPS IN PARTICULAR.

CBIZ will provide the City with updates on any benefits related, legislative changes which may affect the City's employee benefits programs. CBIZ has an in-house legislation team which will provide the City with periodic communications about proposed or passed legislation. This will come in the form of memos, newsletters, seminars, webinars, and checklists.

WORKING WITH A MEXICAN NETWORK PROVIDER INCLUDING BUT NOT LIMITED TO ANALYZING EQUIVALENCES AS NECESSARY TO COMPLY WITH THE ACA AND OTHER LAWS AND REGULATIONS, SEEKING POSSIBILITIES FOR EXPANSION OF THE NETWORK.

CBIZ has experience working with Mexican provider networks and will work with the City's vendor/carrier partners to analyze the cost value of the program, to ensure legal compliance and to seek opportunities for network expansions.

MONITORING LAW AND REGULATION FOR CHANGES RELATED TO HEALTH BENEFITS FOR POLICE, FIREFIGHTERS AND AMBULANCE SERVICES PERSONNEL.

CBIZ will provide the City with updates on any benefits related to legislative changes which may specifically affect the benefits it provides to its public safety personnel. As the State of Arizona's employee benefits consultants, CBIZ has direct access to State of Arizona staff which can assist CBIZ with interpretations and clarifications of regulations specific to this group of employees.

PREPARING BID SPECIFICATIONS AND SOLICITING PROPOSALS FROM INSURANCE MARKETS WHICH SPECIALIZE IN GROUP INSURANCE PLANS AS NEEDED. EVALUATE BIDS AND BIDDERS, INCLUDING ADMINISTRATION, CLAIM PAYMENT PROCEDURES, CUSTOMER SERVICE, NETWORK, RESERVE ESTABLISHMENT POLICIES, FINANCIAL SOUNDNESS, AND IDENTIFYING THE MOST COST-BENEFICIAL PACKAGE FROM AMONG THE VARIOUS BIDDERS.

Our over 30 years of experience working with Arizona based public sector clients has provided us with the experience and knowledge needed to assist the City of San Luis with all aspects of the Request for Proposal process for all lines of insurance coverage and employees benefits related benefits including all of the requirements noted above.

INTERFACING WITH INSURANCE CARRIERS AS NEEDED TO ASSIST THE CITY IN THE RESOLUTION OF PROBLEMS ASSOCIATED WITH THE BENEFIT PROGRAMS.

CBIZ works with all of our clients' carriers and vendors to resolve all employee benefits related issues. Additionally, the City and its employees will have access to CBIZ's in-house Claims Advocate, Angela Schlosser, who will assist the City and its employees with any medical, dental or vision related claims issues.

REVIEWING EXISTING PROGRAMS AND IDENTIFICATION OF RECOMMENDATIONS FOR CHANGES IN PLAN PROVISIONS, ALTERNATIVE DELIVERY SYSTEMS, FUNDING ALTERNATIVES, PREMIUM COST-SHARING AND OTHER AREAS, AS APPROPRIATE.

CBIZ will review all of the City's current programs and plans and will provide recommendations on strategies to meet the City's needs, goals, and objectives.

PROVIDING COMPLETE COBRA ADMINISTRATIVE SERVICES.

CBIZ will provide COBRA administration services through CBIZ's in-house COBRA Administration services department. Click on the QR code for more information about CBIZ's COBRA administration services:



PROVIDING EXCELLENT CUSTOMER SERVICE, INCLUDING BUT NOT LIMITED TO TAKING TIME TO LEARN THE ISSUE AT HAND AND PROVIDING APPROPRIATE SOLUTIONS OR OPTIONS.

CBIZ will fully commit to providing the City and its employees with timely, responsive, consultative, and stellar and customer service.

RESPONDING PROMPTLY TO ALL COMMUNICATIONS FROM THE STAFF AND MANAGEMENT. ADDRESS QUESTIONS, CONCERNS, AND REPORTS OF ISSUES DILIGENTLY AND EXPEDITIOUSLY. PERSONAL SERVICE DIRECTLY WITH THE INDEPENDENT PROFESSIONAL BROKER IS EXPECTED. CALL CENTER SERVICE IS UNACCEPTABLE.

CBIZ will fully commit to providing the City and its employees with timely, responsive, consultative, and stellar and customer service.

I. Broker experience and qualifications

The successful broker shall perform the services necessary to evaluate current insurance coverages and services and potentially replace insurance coverage if it's to the benefit of the City.

A. Broker's experience & qualifications

Demonstrate the Broker's knowledge and experience relative to the terms identified under the Scope of Work. Include a list of similar services provided and a description of the Broker's general organization and names of key personnel, indicating the depth and quality of experience.

C. Identification and organization of the proposed team

Please provide the number of licensed employee benefits staff with five (5) years of commercial lines experience, for the following categories:

1. Brokers, and
2. Other professional staff.

CBIZ Background

Our local agency has been providing service to employers in Arizona for over 43 years. Our national CBIZ organization was founded in 1987 and the CBIZ Arizona office became part of CBIZ in 1991.

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Who We Are Nationally

At CBIZ, your team starts with your local professionals but expands far beyond there. An entire group of specialized experts across the country stands ready to ensure all of your specific, unique business needs are met. CBIZ (NYSE: CBZ) is in the business of making things easier for our clients. As a leading provider of Employee Benefits Consulting Services, CBIZ is one of the nation's leading providers of professional advisory services, focused on accounting, benefits and insurance, HR, and payroll solutions. On a national basis, we employ over 6,000 associates engaged in a variety of disciplines.

Our corporate headquarters is located in Cleveland, Ohio, with the benefits consulting practice based in Kansas City, Missouri. CBIZ was founded in 1987 and our long-standing tenure as a top broker of U.S. Business allows us to navigate the complex and evolving insurance industry. We help our clients mitigate escalating health care costs through a creative benefits strategy, comprehensive and robust services, and reasonable fees.

Who We Are Locally

CBIZ Arizona is comprised of 47 dedicated staff members located in our Tucson and Phoenix offices. Our staff of professionals come from a wide variety of employee benefits, human resources, insurance carrier and wellbeing backgrounds. We believe that this diversity of experience enables our team to provide our clients with unique and varied approaches and strategies to meet their employee benefits needs, strategic goals, and objectives. Because of our size and reputation, CBIZ is recognized as a top broker/consultant by all of the major medical and ancillary carriers nationally and in the Arizona market.



Public Sector Experience

CBIZ is a multi-service company providing companies with a wide variety of professional services. Both locally and nationally, we have years of experience working with many public sector employers and with an understanding of their unique consulting and procurement circumstances. We have assisted all these clients with all their formal and informal RFPs while adhering to their procurement and purchasing requirements.

We were recently re-awarded a five (5) year employee benefits consulting contract by the State of Arizona, and this is our 2nd award of this contract. Our Arizona office currently provides Employee Benefit Consulting services to **25 public sector employers** including:

- 13 government entities
- 10 public school districts
- 1 community college
- 1 governmental hospital district

A list of CBIZ's public entity clients is provided in **SECTION 2**.

We have assembled an experienced team of employee benefits professionals to service the City of San Luis and its Employee Benefits Trust.

Team members include:

Local Key Personnel

Oscar A. Diaz, Vice President of Business Development/Consultant



Oscar Diaz will act as the City of San Luis's lead Consultant and will work with the local and national CBIZ team to develop and ensure execution of the City of San Luis's employee benefits strategies. Oscar will also be responsible for driving the renewal process and for negotiating with carriers and vendors on behalf of the City of San Luis. Oscar has been with CBIZ for over 25 years and has worked with many fully and self-funded public sector industry employers during his 34-year employee benefits career. *Oscar holds an Arizona, Accident and Health or Sickness Life License.*

Some of Oscar's current public sector clients include:

▪ City of Nogales	▪ Pima County Government
▪ City of South Tucson	▪ Santa Cruz Valley Unified School District
▪ City of Tombstone	▪ State of Arizona/ADOA
▪ Northwest Fire District	▪ Town of Oro Valley

Jennifer Aragon, Account Executive



Jennifer Aragon will be working with Oscar Diaz and the local and national CBIZ teams to develop and ensure execution of the City of San Luis's employee benefits strategies. Kristine will also act as a day-to-day liaison with the City of San Luis's and its carriers and vendors. Additionally, Kristine will be involved with CBIZ's Actuarial and Analytics team to ensure that CBIZ and the City of San Luis's carriers and vendors are providing timely and accurate claims data to the City of San Luis. Jennifer has worked in the employee benefits consulting industry for over 20 years and works with several of CBIZ Arizona's public sector clients. *Jennifer holds an Arizona, Accident and Health or Sickness Life License.*

Debbie Jamison, Account Manager



Debbie will act as an in-office liaison and will be working with the local CBIZ team, national CBIZ team and the City of San Luis's carriers to ensure that the City of San Luis's day-to-day employee benefits needs and being consistently met. Debbie has worked in the employee benefits consulting industry for over 24 years and works with many of CBIZ Arizona's public sector clients. *Debbie holds an Arizona, Accident and Health or Sickness Life License.*



Cameron Dugan, Analyst

Cameron Dugan will be working with the local CBIZ team to produce the City of San Luis's, customized claims reports. On an annual basis, Cameron will also work to support CBIZ's renewal negotiations efforts and to assist with the pricing of alternative medical plan benefits and stop-loss insurance limit options. Cameron has worked in the employee benefits consulting industry for over 25 years.

Anisa Karczynski, Wellbeing Account Executive



Anisa Karczynski and the national CBIZ Wellbeing team will work directly with the City of San Luis to develop and ensure effective execution of its wellness and wellbeing programs. She will also be working closely with the City of San Luis's carrier and vendor partners to ensure that the City of San Luis's wellness objectives and goals are being consistently met. Anisa has been a wellbeing professional for over 10 years.

Angela Schlosser, Claims Advocate



Angela's position is quite unique in that very few employee benefits brokers offer in-house, dedicated claims advocacy services to their clients. Angela Schlosser works directly with insurance carriers, providers, and on some occasions with collection agencies to resolve all medical, dental and vision insurance related claims issues on behalf of the City of San Luis's employees and dependents. She will work with all parties to see claim issues through to their full resolution. Additionally, Angela will provide employees with plan and Explanation of Benefits education. Angela has been in the employee benefits consulting business for over 16 years. *Angela holds an Arizona, Accident and Health or Sickness Life License.*

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Please refer to **SECTION 1** for Key Personnel biographies.

Supplementary Local Personnel

Rebecca White, Marketing Specialist

Rebecca White is a Marketing Specialist and will be working with Maribeth Petrocelli on the development of communications for the City of San Luis. Alayna will also be available to work directly with the City of San Luis on the design of other pertinent employee benefits related materials.

Rebecca will be available to design and produce a wide variety of communication materials that can be provided in both print and electronic formats including:

- Benefit plan summaries
- Open enrollment booklets
- Benefits educational presentations
- Flyers
- Other custom, client-centric communication materials

National Supplementary Personnel

- **Actuarial Services:** Dave Rubadue, FSA, CLU, MAMA, Practice Lead
- **Pharmacy Consulting Services:** Michael Zucarelli, Practice Lead
- **Regulatory Affairs and Compliance Services:** Karen McLeese, Esq., Practice Lead
- **Engagement and Wellbeing Solutions:** Emily Noll, MS, Practice Lead
- **Health Innovations Practice:** Cole Harris
- **Human Resources Outsourcing & Consulting Services:** Claire Bissot, Practice Lead
- **Clinical Consulting Services:** Erin Eason, Practice Lead

D. Additional Information Requested:

1. **List Arizona public entity accounts, dates of service, including the name and phone number of the primary contact for similar projects done by the personnel to be involved in these projects.**

A list of CBIZ's public entity clients is provided in **SECTION 2**.

2. **Discuss any additional services the Consultant normally offers in conjunction with providing the lines of insurance that are referenced in the RFQ.**

Other CBIZ Services

Please note that your CBIZ service team will have access to the internal resources listed below for consultative purposes. If the City chooses to enter into a formal engagement with one of these CBIZ service areas, CBIZ will provide separate pricing to the City for these services:

- Human Resources consulting includes reviews of hiring practices, interviewing practices, personnel policies, and creation of employee handbooks.
- Compensation and pay analyses and practices – ***Note: In 2022, CBIZ conducted compensation studies for Pima County, Eastern Arizona College and Northwest Fire Department which led to changes in these entities' compensation practices. Furthermore, Eastern Arizona College has contracted with CBIZ to revamp their job descriptions.***

- Job descriptions review and modifications or creation of new job descriptions
- GASB liability consulting related to ASRS and PSPRS retirement liabilities – *Note: In 2021, CBIZ conducted a PSRS retirement liabilities study for the Town of Oro Valley which led the Town to partially finance those liabilities and enabling the Town to utilize the freed-up funds to be used for other purposes.*
- Retirement plan services consulting
- Retirement plan actuarial services
- Payroll consulting and payroll services
- HRIS consulting and HRIS online enrollment platform services
- Cybersecurity consulting services
- Job recruitment services
- Audit services (limited)

SECTION 7

- **Professional Services Agreement
(Exhibit C)**
- **Completed Substitute W-9 form
(Exhibit D)**
- **Conflict of Interest Disclosure
(Exhibit E)**

EXHIBIT C – PROFESSIONAL SERVICES AGREEMENT

Please note that the enclosed **EXHIBIT C – PROFESSIONAL SERVICES AGREEMENT** document has not been signed. There are several provisions within this document listed below that CBIZ cannot agree to in their current form. We are, however, willing to discuss these with the City of San Luis if we are awarded this contract.

12. J. (4) – Notice of cancellation provision cannot be agreed to in its current form. CBIZ would agree to the following replacement language, “Notice of cancellation will be provided in accordance with policy provisions”.

Number 14. cannot be agreed to in its current form. CBIZ would agree to the following replacement language, “Notice of cancellation will be provided in accordance with policy provisions.

EXHIBIT C – PROFESSIONAL SERVICES AGREEMENT

This agreement (“Contract”) is made and entered into this _____ day of _____, 2023, by and between the San Luis Employee Health Benefit Trust (“City”), and _____ (“Consultant”), to provide Employee Benefits Brokerage and Consultation Services (“Services”).

WHEREAS, City desires to retain a consultant to furnish Professional services and to make payment for the same in accordance with the terms and conditions set forth in this Agreement, including all attachments and addenda, including the Request for Qualifications and Proposal, which are appended hereto by mutual agreement of the parties; and

WHEREAS, in procuring these services, City issued **RFQ/RFP No. 2023-01** seeking a qualified Broker/Consultant to provide Employee Benefits Insurance Brokerage and Consultation Services; and

NOW, THEREFORE, City agrees to retain and does hereby retain Broker/Consultant and Broker/Consultant agrees to provide the services required according to the terms and conditions and for the consideration hereinafter set forth:

1. **CONSULTANT'S DUTIES:** Consultant agrees to perform the following professional services as described in Exhibit B which is incorporated into this Contract by this reference. City shall furnish the Consultant with all data, information and other support for the scope of work described in Exhibit B.
2. **KEY PERSONNEL**
It is essential that the Consultant provide adequate experienced personnel, capable of and devoted to the successful accomplishment of work to be performed under this contract. The Consultant must agree to assign specific individuals to the key positions. The Consultant agrees that, once assigned to work under this contract, key personnel shall not be removed or replaced without written notice to the City. If key personnel are not available for work under this contract for a continuous period exceeding thirty calendar days or are expected to devote substantially less effort to the work than initially anticipated, the Consultant shall immediately notify the City, and shall, subject to the concurrence of the City, replace such personnel with personnel of substantially equal ability and qualifications.
3. **COMPENSATION:** The negotiated fee process shall be utilized for this Contract. For services rendered under this Contract, the Consultant shall be paid in accordance with the negotiated fee schedule. Payment shall be made monthly on the basis The City shall make every effort to process payment for the purchase of materials or services within thirty (30) calendar days after receipt of materials or services and a correct invoice.
4. **TERM AND RENEWAL:** The term of the Contract shall commence upon the award of the Contract and shall remain in effect for a period of three (3) years, unless terminated, canceled, or extended as otherwise provided herein. The Consultant

agrees that the City shall have the right, at its sole option, to renew the contract for one (1) additional two-year period or portion thereof. In the event that the City exercises such rights, all terms, conditions and provisions of the original Contract shall remain the same and apply during the renewal period with the possible exception of price and minor scope additions and/or deletions.

5. **CONSULTANT'S STANDARD OF PERFORMANCE:** While performing the services, Consultant shall exercise the reasonable professional care and skill customarily exercised by reputable members of the broker/consultant profession and shall use reasonable diligence and best judgment while exercising its professional skill and expertise. Consultant shall be responsible for all errors and omissions Consultant commits in the performance of this Agreement that are a breach of this standard.
7. **CONFIDENTIALITY:** Consultant, and any subcontractors or individuals hired by Consultant to perform the services under this Contract, shall keep any information concerning City matters confidential and agree that they will not make any statement, give an interview or provide any information to any person, corporation or other entity, including without limitation any media source, in relation to the project or the services to be provided under this Agreement without the prior written consent of City. Consultant, and any subcontractors or individuals hired by Consultant, agree not to disclose to any other person or entity (unless required by law) any confidential information concerning City matters during and after this Contract.
8. **NOTICES:** All notices to the other party required under this Contract shall be in writing and sent by first class certified mail, postage prepaid, return receipt requested, addressed to the following personnel:

If to City: City of San Luis Employee Health Benefits Trust
 Attn: City Manager
 P.O. Box 1170
 San Luis, AZ 85349

If to Consultant: _____
 Attn: _____

9. **TERMINATION:**
 - a. This Contract may be terminated at any time by mutual written consent.
 - b. The City may terminate this Contract with or without cause, upon giving the Consultant at least sixty (60) days' written notice to Consultant.
 - c. If this Contract is terminated, the City shall be liable only for payment under the payment provisions of this Contract for services rendered and accepted

material received by the City before the effective date of termination. In the event of such termination, Consultant shall deliver to City all work in any state of completion or incompleteness at the date of effective termination.

- d. The City reserves the right to cancel the whole or any part of this Contract due to failure of Consultant to carry out any term, promise, or condition of the Contract. The City will issue a written ten (10) day notice of default to Consultant for acting or failing to act as in any of the following:
- In the opinion of the City, Consultant provides personnel that do not meet the requirements of the contract;
 - In the opinion of the City, Consultant fails to perform adequately the stipulations, conditions or services/specifications required in this contract;
 - In the opinion of the City, Consultant attempts to impose on the City personnel or materials, products or workmanship, which is of an unacceptable quality.
 - Consultant fails to furnish the required service and/or product within the time stipulated in the contract;
 - In the opinion of the City, Consultant fails to make progress in the performance of the requirements of the contract and/or give the City a positive indication that Consultant will not or cannot perform to the requirements of the contract.
10. **SUBCONTRACTORS:** Consultant shall, within ten (10) days after the execution of this Contract and before awarding any subcontract, furnish City with a written list of proposed subcontractors (including addresses and contact information), if any, and shall not employ any that City may object to for any reason. The City shall not unreasonably withhold approval and shall notify the Consultant of the City's position within 15 days of receipt of the written list of proposed subcontractors. Consultant agrees that it is as fully responsible to City for the acts and omissions of its subcontractors and of persons either directly or indirectly employed by them as it is for the acts and omissions of persons directly employed by Consultant. Consultant is responsible for contract performance whether or not subcontractors are used. Nothing contained in the Contract shall create any contractual relations between any subcontractor and City.
11. **RECORDS:** Records of Consultant's labor, payroll, and other costs pertaining to this Agreement shall be kept on a generally recognized accounting basis and made available to City for inspection on request and at the city's expense. Broker/Consultant shall maintain records for a period of at least two (2) years after termination of this Agreement and shall make such records available during that retention period for examination or audit by City personnel during regular business hours.

12. INSURANCE-GENERAL:

- a. **Insurer Qualifications.** Without limiting any obligations or liabilities of the Consultant, the Consultant shall purchase and maintain, at its own expense, hereinafter stipulated minimum insurance with insurance companies duly authorized by the State of Arizona with an AM Best, Inc. rating of A- or above with policies and forms satisfactory to the City. Failure to maintain insurance as specified herein may result in termination of this Agreement at the City's option.
- b. **No Representation of Coverage Adequacy.** By requiring insurance herein, the City does not represent that coverage and limits will be adequate to protect the Consultant. The City reserves the right to review any and all of the insurance policies and/or endorsements cited in this Agreement but have no obligation to do so. Failure to demand such evidence of full compliance with the insurance requirements set forth in this Agreement or failure to identify any insurance deficiency shall not relieve the Consultant from, nor be construed or deemed a waiver of, its obligation to maintain the required insurance at all times during the performance of this Agreement.
- c. **Additional Insured.** All insurance coverage and self-insured retention or deductible portions, except Workers' Compensation/Employer's Liability insurance and Professional Liability insurance, if applicable, shall name, to the fullest extent permitted by law for claims arising out of the performance of this Contract, the City, its agents, representatives, officers, directors, officials and employees as Additional Insured as specified under the respective coverage sections of this Contract.
- d. **Coverage Term.** All insurance required herein shall be maintained in full force and effect until all work or services required to be performed under the terms of this Contract are satisfactorily performed, completed and formally accepted by the City, unless specified otherwise in this Agreement.
- e. **Primary Insurance.** The Consultant's insurance, except Workers' Compensation/Employer's Liability insurance and Professional Liability insurance, if applicable, shall be primary insurance with respect to performance of this Contract and in the protection of the City as an Additional Insured.
- f. **Claims Made.** In the event any insurance policies required by this Agreement are written on a "claims made" basis, coverage shall extend, either by keeping coverage in force or purchasing an extended reporting option, for three (3) years past completion and acceptance of the services. Such continuing coverage shall be evidenced by submission of annual Certificates of Insurance and endorsements citing applicable coverage is in force and contains the provisions as required herein for the three-year period.
- g. **Waiver.** All policies, except for Professional Liability, including Workers' Compensation insurance, shall contain a waiver of rights of recovery (subrogation) against the City of San Luis or the City of San Luis Employee Benefits Trust, its agents, representatives, elected officials, officers and employees for any claims

arising out of the work or services of the Consultant. The Consultant shall arrange to have such subrogation waivers incorporated into each policy via formal written endorsement thereto on a blanket basis.

- h. **Policy Deductibles and/or Self-Insured Retentions.** The policies set forth in these requirements may provide coverage that contains deductibles or self-insured retention amounts. Such deductibles or self-insured retention shall not be applicable with respect to the policy limits provided to the City. The Consultant shall be solely responsible for any such deductible or self-insured retention amount.
- i. **Use of Subcontractors.** If any work under this Agreement is subcontracted in any way, the Consultant shall execute written agreement with the Subcontractor containing the indemnification provisions and insurance requirements (unless waived by City in the City's sole discretion) set forth herein protecting the City and the Consultant. The Consultant shall be responsible for executing the agreement with the Subcontractor and obtaining certificates of insurance verifying the insurance requirements.
- j. **Evidence of Insurance.** Prior to commencing any work or services under this Contract, the Consultant shall furnish the City with certificate(s) of insurance, and formal endorsements as required by this Contract, issued by the Consultant's insurer(s) as evidence that policies are placed with acceptable insurers as specified herein and provide the required coverages, conditions and limits of coverage specified in this Contract and that such coverage and provisions are in full force and effect. If a certificate of insurance is submitted as verification of coverage, the City shall reasonably rely upon the certificate of insurance as evidence of coverage, but such acceptance and reliance shall not waive or alter in any way the insurance requirements or obligations of this Agreement. If any of the above-cited policies expire during the life of this Agreement, it shall be the Broker/Consultant's responsibility to forward renewal certificates within ten (10) days after the renewal date containing all the aforementioned insurance provisions. Certificates of insurance shall specifically include the following provisions:
 - (1) The City, its agents, representatives, officers, directors, elected officials, Employee Benefits Trustees and employees are Additional Insureds for Consultant's Commercial General Liability Insurance.
 - (2) The Broker/Consultant 's insurance shall be primary and non-contributory insurance as respects performance of the Agreement, except Workers' Compensation/Employer's Liability insurance and Professional Liability insurance.
 - (3) All policies, excluding Professional Liability, waive rights of recovery (subrogation) against the City, its agents, representatives, officers, officials and employees for any claims arising out of work or services performed by the Consultant under this Contract.

- (4) A 30-day advance notice cancellation provision. If ACORD certificate of insurance form is used, the phrases in the cancellation provision "endeavor to" and "but failure to mail such notice shall impose no obligation or liability of any kind upon the company, its agents or representatives" shall be deleted. Certificate forms other than ACORD form shall have similar restrictive language deleted.

13. REQUIRED INSURANCE COVERAGE

- a. Commercial General Liability. The Broker/Consultant shall maintain "occurrence" form Commercial General Liability insurance with an unimpaired limit of not less than \$1,000,000 for each occurrence, \$1,000,000 Products and Completed Operations Annual Aggregate and a \$2,000,000 General Aggregate Limit. Such limits may be met in combination of primary and excess policies. The policy shall cover liability arising from premises, operations, independent contractors, products-completed operations, bodily injury or death, personal injury, advertising injury and property damage. Coverage under the policy will be at least as broad as ISO policy forms CG 00 010 or equivalent thereof, including but not limited to, separation of insured's clause. To the fullest extent allowed by law, for claims arising out of the performance of this Agreement, the City, its agents, representatives, officers, officials, volunteers and employees shall be cited as an Additional Insured under ISO, Commercial General Liability Additional Insured Endorsement form CG 20 10, or equivalent, which shall read "Who is an Insured (Section II) is amended to include as an insured the person or organization shown in the Schedule, but only with respect to liability arising out of "your work" for that insured by or for you."
- b. Vehicle Liability. The Broker/Consultant shall obtain Mexican insurance on any vehicle used to travel to Mexico in performance of this Contract with a minimum limit of \$1,000,000 each occurrence on the Consultant's owned, hired and non-owned vehicles assigned to or used in the performance of the Broker/Consultant's work or services under this Contract.
- c. Professional Liability (Errors and Omissions Liability). Broker/Consultant shall maintain Professional Liability insurance covering negligent errors and omissions arising out of the Services performed by the Consultant, or anyone employed by the Consultant, or anyone for whose negligent acts, mistakes, errors and omissions the Consultant is legally liable, with an unimpaired liability insurance limit of \$5,000,000 each claim and \$5,000,000 all claims. In the event the Professional Liability insurance policy is written on a "claims made" basis, Broker/Consultant warrants that any retroactive date under the policy shall precede the effective date of this Agreement; and that either continuous coverage will be maintained or an extended discovery period will be exercised for a period of three (3) years beginning at the time work under this Contract is completed.
- d. Workers' Compensation Insurance. Broker/Consultant shall maintain Workers' Compensation insurance to cover obligations imposed by federal and state statutes having jurisdiction of Consultant's employees engaged in the

performance of work or services under this Agreement and shall also maintain Employers Liability Insurance of not less than \$500,000 for each accident, \$500,000 disease for each employee and \$1,000,000 disease policy limit.

14. **CANCELLATION AND EXPIRATION NOTICE:** Insurance required herein shall not expire or be canceled without thirty (30) days prior written notice to the City.
15. **RIGHT OF CITY TO CONTRACT WITH OTHERS:** Nothing in this Agreement shall imply City is obligated to obtain the services described herein with only the Consultant.
16. **UNCONTROLLABLE FORCES / FORCE MAJEURE:** City and Broker/Consultant shall exert all efforts to perform their respective responsibilities under this Contract. However, neither party shall hold the other party responsible for inability to render timely performance if such inability is a direct result of a force beyond its control, including but not limited to the following: strikes, lockouts, embargoes, failure of carriers, inability to obtain transportation facilities, acts of God or the public enemy, or other events beyond the control of the other or the other's employees and agents.
17. **INDEMNIFICATION:** To the fullest extent allowed by law, Consultant shall defend, indemnify, and hold City, its officers, elected official, trustees, and employees harmless from any and all loss, damage, claim for damage, liability, expense, or cost, including reasonable attorneys' fees, which arise out of, or is in any way connected with the performance of work under this Contract by Consultant, or any of Consultant's employees, agents or subcontractors, and from all claims by Consultant's employees, subcontractors and agents for compensation for services rendered to Consultant in the performance of this Contract, notwithstanding that City may have benefited from their services. This indemnification provision shall only apply to any and all negligent acts or omissions, willful misconduct or negligent conduct, whether active or passive, on the part of Consultant or Consultant's employees, subcontractors or agents. This section shall survive the expiration or early termination of the Contract. The Consultant's obligation under this section shall not extend to any liability caused by the sole negligence of the City or its employees.
18. **WAIVER OF TERMS AND CONDITIONS:** The failure of City or Consultant to insist in any one or more instances on performance of any of the terms or conditions of this Contract or to exercise any right or privilege contained herein shall not be considered as thereafter waiving such terms, conditions, rights or privileges, and they shall remain in full force and effect. **INDEMNIFICATION:** Consultant shall indemnify, defend, and hold harmless the City, from any and all claims, demands, suits, actions, proceedings, loss, cost, and damages of every kind and description, including any reasonable attorney's fees and/or litigation expenses, which may be brought or made against or of any person, caused by, arising out of, or contributed to, in part, by reasons of any act, omission, professional error, fault, mistake, or negligence of the Consultant, its employees, agent, representatives, or

subcontractors, their employees, agents, or representatives in connection with or incidental to the performance of this Agreement, or arising out of Worker's Compensation Claims, unemployment compensation claims, or unemployment disability compensation claims of employees of the Consultant and/or its subcontractors or claims under similar such laws or obligations.

19. **INDEPENDENT CONTRACTOR:** Consultant shall at all times during Consultant's performance of the services retain Consultant's status as independent contractor. Consultant's employees shall under no circumstances be considered or held to be employees or agents of City, and City shall have no obligation to pay or withhold state or federal taxes or provide workers' compensation or unemployment insurance for or on behalf of them or the Consultant. It is clearly understood that each party shall act in its individual capacity and not as an agent, employee, partner, joint venture, or associate of the other. The City and the Consultant intend that an independent contractor relationship and not an employer-employee relationship is created by this Contract. The City is interested only in the results to be achieved, and not the conduct and control of the performance of the services contemplated in this Contract. The Consultant's rights include but are not limited to control of the work, manner and methods of the work, and the right to contract with other entities. The City's rights include but are not limited to inspection and approval of the work and the right to contract with others to perform the work. An employee or agent of one party shall not be deemed or construed to be the employee or agent of the other party for any purpose whatsoever. Consultant shall not be entitled to any City employee benefits and shall not be compensated in the form of salaries, or to paid vacation or sick days by the City, and that such days do not accumulate for the use of same at a later date.
20. **ARBITRATION.** It is understood and agreed that no provision of the contract relating to arbitration or requiring arbitration shall apply to or be binding upon the City except by the City's express written consent given subsequent to the execution of the contract. However, at the City's sole option, or by other means expressly approved by the City, disputes may be resolved through arbitration. The dispute shall be resolved as provided for in A.R.S. Sec. 12-1501, et seq. Consultant shall continue to render the services required by this contract without interruption, notwithstanding the provisions of this section.
21. **GOVERNING LAW AND VENUE:** The terms and conditions of this Agreement shall be governed by and interpreted in accordance with the laws of the State of Arizona. Any action at law or in equity brought by either party for the purpose of enforcing a right or rights provided for in this Agreement, shall be tried in a court of competent jurisdiction in Yuma County, State of Arizona. The parties hereby waive all provisions of law providing for a change of venue in such proceeding to any other county. In the event either party shall bring suit to enforce any term of this Contract or to recover any damages for and on account of the breach of any term or condition in this Contract, it is mutually agreed that the prevailing party in such action shall recover all costs including: all litigation and appeal expenses, collection expenses, reasonable attorneys' fees, necessary witness fees, expert fees, and court costs to be determined by the court in such action.

22. **OWNERSHIP OF RECORDS AND REPORTS:** All of the files, reports, documents, information and data prepared or assembled by Consultant under this Contract shall be and remain the property of City and shall be forwarded to City at any time City requires such papers. They shall not be used or released by the Consultant or any other person except with prior written permission by the City.
23. **LICENSE:** Broker/Consultant represents and warrants that any license necessary to perform the work under this Agreement is current and valid. Broker/Consultant understands that the activity described herein may constitute “doing business in the “City of San Luis” and Broker/Consultant agrees to obtain any necessary business license pursuant to San Luis City Code Chapter 5.05. and keep such license current during the term of this Contract. Any activity by subcontractors within the corporate city limits, will invoke the same business license regulations on any subcontractors, and Consultant ensures its subcontractors will obtain any required business license.
24. **NON-ASSIGNMENT:** This Contract has been entered into based upon the personal reputation, expertise and qualifications of the Consultant. Neither party to this Contract shall assign its interest in the Contract, either in whole or in part. Consultant shall not assign any monies due or to become due to it hereunder without the prior written consent of City. No delegation of any duty of the Consultant shall be made without prior written permission of the City.
25. **THIRD PARTY BENEFICIARIES:** There are no third-party beneficiaries of this Contract.
26. **ENTIRE AGREEMENT:** This Contract and its exhibits and attachments represent the entire agreement between City and Consultant and supersede all prior negotiations, representations or agreements, either express or implied, written or oral. It is mutually understood and agreed that no alteration or variation of the terms and conditions of this Contract shall be valid unless made in writing and signed by the parties hereto. Written and signed amendments shall automatically become part of the Contract, and shall supersede any inconsistent provision therein; provided, however, that any apparent inconsistency shall be resolved, if possible, by construing the provisions as mutually complementary and supplementary. This Contract is intended by the parties as a final expression of their agreement and is intended also as a complete and exclusive statement of the terms of this agreement. No course of prior dealings between the parties and no usage of the trade shall be relevant to supplement or explain any term used in this Contract. Acceptance or acquiescence in a course of performance rendered under this Contract shall not be relevant to determine the meaning of this Contract even though the accepting or acquiescing party has knowledge of the nature of the performance and opportunity to object.
27. **SEVERABILITY:** If any part, term or provision of this Agreement shall be held illegal, unenforceable or in conflict with any law by a court of competent jurisdiction or controlling legislation, the validity of the remaining portions and provisions hereof shall not be affected.

28. **CONFLICTS OF INTEREST:** The City may cancel this contract without penalty or further obligation pursuant to A.R.S. Section 38-511 if any person significantly involved in initiating, negotiating, securing, drafting, or creating the contract, on behalf of the City is or becomes, at any time while the contract or any extension of the contract is in effect, an employee of, or a contractor to any other party to this contract with respect to the subject matter of the contract. Such cancellation shall be effective when written notice from the Finance Department is received by the parties to this contract, unless the notice specifies a later time.
29. **IMMIGRATION:** To the extent applicable under ARIZONA REVISED STATUTE SECTION §41-4401, the Consultant and its subcontractors warrant compliance with all federal immigration laws and regulations that relate to their employees and compliance with the E-Verify requirements under A.R.S. § 23-214 (A).
- a. The Consultant or subcontractor's breach of the above-mentioned warranty shall be deemed a material breach of the Agreement and may result in the termination of the Agreement by the City of San Luis.
 - b. The City of San Luis retains the legal right to randomly inspect the papers and records of the Consultant and its subcontractors who work on the contracts ensure that the Consultant and its subcontractors are complying with the above-mentioned warranty.
30. **ISRAEL BOYCOTT:** To the extent permitted by law, Consultant certifies that it does not participate in and agrees not to participate during the term of this Contract a boycott of Israel in accordance with A.R.S. §35-393.01.
31. **FORCED LABOR:** Under A.R.S. § 35-394, the Consultant certifies that the Consultant is not currently engaged in and agrees for the duration of the contract it will not use the forced labor of ethnic Uyghurs in the People's Republic of China, any of their goods or services, or use any subcontractors or supplies that use their forced labor.
32. **CONTRACT AMENDMENTS:** This contract shall be modified only by a written contract amendment signed by the City of San Luis Employees Benefit Trust and persons duly authorized to enter into contracts on behalf of the Consultant.
33. **PROVISIONS REQUIRED BY LAW:** Each and every provision of law and any clause required by law to be in the contract shall be read and enforced as though it were included herein, and if through mistake or otherwise any such provision is not inserted, or is not correctly inserted, then upon the application of either party the contract shall forthwith be physically amended to make such insertion or correction.

IN WITNESS WHEREOF, the parties have caused this Agreement to be signed by their duly authorized representatives as of the day and year first above written.

CONSULTANT: _____

By: _____

Its: _____

CITY OF SAN LUIS EMPLOYEE BENEFITS TRUST

Tadeo Azael De La Hoya
Board of Trustees Chair

ATTEST:

Sonia Cornelio
City Clerk

APPROVED AS TO FORM:

City Attorney

Request for Taxpayer Identification Number and Certification

Give Form to the
requester. Do not
send to the IRS.

► Go to www.irs.gov/FormW9 for instructions and the latest information.

Print or type.
See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank. CBIZ Benefits & Insurance Services, Inc.	
2 Business name/disregarded entity name, if different from above	
3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes. ☐ Individual/sole proprietor or single-member LLC ☒ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate ☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner. ☐ Other (see instructions) ►	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ <i>(Applies to accounts maintained outside the U.S.)</i>
5 Address (number, street, and apt. or suite no.) See instructions. 700 W 47th Street, Suite 1100	Requester's name and address (optional)
6 City, state, and ZIP code Kansas City, MO 64112	
7 List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number								
			-			-		
or								
Employer identification number								
3	1	-	1	5	8	2	0	9
								8

Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
- I am a U.S. citizen or other U.S. person (defined below); and
- The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	Signature of U.S. person	Carol L. Morris	Date	9/7/2023
	Chief Financial Officer			

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
 - Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
 - Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
 - Form 1099-S (proceeds from real estate transactions)
 - Form 1099-K (merchant card and third party network transactions)
 - Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
 - Form 1099-C (canceled debt)
 - Form 1099-A (acquisition or abandonment of secured property)
- Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.

EXHIBIT E – CONFLICT OF INTEREST DISCLOSURE



VENDOR CONFLICT OF INTEREST DISCLOSURE

INSTRUCTIONS

Vendors shall not try to gain an unfair competitive advantage or influence the ability of (City of San Luis) COSL employees to make impartial and objective decisions on behalf of COSL.

All vendors interested in conducting business with COSL must complete and return the Vendor Conflict of Interest Disclosure Form found on the following page in order to be eligible to be awarded a contract with COSL. Please note that all vendors are subject to comply with COSL's conflict of interest policies provided below.

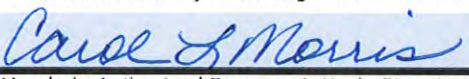
1. No COSL employees (e.g., elected City official) or employee has an ownership interest of more than 5% in vendor's company.
2. No COSL employee is an officer, director, partner or proprietor of vendor's company.
3. No COSL employee is employed by or being considered for employment by vendor's company.
4. No COSL employee work as a consultant or has a contractual relationship with vendor's company.
5. No COSL employee will derive a personal financial gain or loss from this contract.
6. No relative of a COSL employee will derive a personal financial gain or loss from this contract. (Relatives include a father, mother, son, daughter, husband, wife, brother, sister, father-in-law, mother-in-law, son-in-law, or daughter-in-law.)

If a vendor has one or more relationships with a COSL employee or a relative of a COSL employee that meets the criteria described above, then the vendor shall disclose the information by completing the Conflict of Interest Form on the following page.



VENDOR CONFLICT OF INTEREST DISCLOSURE FORM

Disclosing a potential conflict of interest does not disqualify vendors. In the event vendors do not disclose potential conflicts of interest, and they are detected by ("City of San Luis") COSL vendor may be disqualified from doing business with COSL.

Bid/Solicitation/Contract Number: RFQ/RFP No. 2023-01		Name of COSL Employee(s) Working on Vendor's Current Contract(s) with COSL:	
Vendor's Name: CBIZ Benefits & Insurance Services, Inc.		Vendor's Phone: 816-945-5500	
Vendor's Authorized Representative Name and Title: Carol L. Morris - Chief Financial Officer		Authorized Representative's Phone: 816-945-5500	
NAME(S) OF COSL EMPLOYEE(S) WITH POTENTIAL CONFLICT OF INTEREST			
Name of COSL employee(s), or relatives with whom there may be a potential conflict of interest. If more than five, attach a second form.		Relationship of COSL employee(s) and/or relative(s) to vendor's company from list above (e.g. 1(a), 2, etc.). Please list all that apply:	
1.			
2.			
3.			
4.			
☒ Vendor has no conflict of interest to report. ☒ Vendor hereby declares it has not and will not provide gifts or hospitality of any dollar value or any other gratuities to any COSL employee to obtain or maintain a contract. ☒ I certify that this Conflict of Interest Disclosure has been examined by me and that its contents are true and correct to my knowledge and belief and I have the authority to so certify on behalf of the Vendor.			
 Vendor's Authorized Representative's Signature:		9/7/2023 Date:	

For COSL Only if Conflict Noted

Name of COSL Employee:	Signature:	Date:
Note:		



SECTION 8

CBIZ CLIENT CASE STUDIES

SECTION 8

CASE STUDIES/2022 CLIENTS

CBIZ believes strongly in self-funding as an effective way for employers to have more control over their medical insurance plan strategy and as an effective way to control costs. Our belief in self-funding is evident by our Arizona office having 57 clients in alternative/self-funded arrangements. On a national basis, CBIZ has hundreds of clients also participating in these arrangements. CBIZ nationally and locally has invested and continues to invest in resources to support our self-funded clients and will be highlighting those resources in our response.

CBIZ has been recommending and implementing alternative/self-funded strategies for our clients for over 30 years and we have long-standing and strong relationships with a variety of Third-Party Administrators (TPA), Pharmacy Benefit Managers (PBM) and stop-loss insurance carriers.

Within this document, we will be highlighting several case studies and strategies that have been highly successful for some of our clients.

Note: All case studies provided below are for Arizona based employers.

CBIZ CLIENT CASE STUDIES

In 2022 we acquired three (3) new, self-funded clients which had had long-term relationships with their employee benefits brokers but were looking for more innovative approaches to how to manage their benefits plans and costs. The three (3) clients are:

- A community college with 260 employees
- A fire district with 300 employees
- A private, trade school with over 600 employees

CASE STUDY #1

Medical Plan Funding Type: Self-funded

Background: This case study is for a rural Arizona community college with 260 employees. This client had been with their broker for over 10 years and had been self-funded during that period. They had made some benefit changes to their medical plan during that time, but with their broker did not aggressively negotiate renewals on their behalf. In April 2022, CBIZ was awarded a broker-of-record letter based on its reputation for effectively working with public sector, self-funded employers.

Process: The client's renewal was on July 1 and because of this, CBIZ did not have enough time to conduct a thorough market search for their new client. CBIZ did however, conduct a thorough assessment of their historical BlueCross BlueShield of Arizona's (BCBSAZ) renewals along with their 2022/2023 plan year renewal.

Our analysis quickly revealed that the client's pharmacy benefit rebates credit was woefully low and that the client's administration costs were too high. As such, the local CBIZ team recruited the assistance of CBIZ's Pharmacy team to assess the client's prescription drug spend and compared it the BCBSAZ's prescription drug credit.

Outcome: Our review of the rebate credit and the administrative fees resulted in a fixed cost savings of \$130K per year. Additionally, the former broker had also implemented a redundant telehealth program. When CBIZ discovered this, CBIZ removed the program and negotiated with BCBSAZ to offer the client a no-cost telehealth program; this resulted in an additional \$15K annual savings. The \$145K savings resulted in CBIZ's fees being funded entirely through by the savings and with enough left over for the client to implement an online enrollment platform at no cost.

CBIZ also worked with the client to create an employee benefits consulting communications campaign for their 2023 open enrollment period which was well received by their employees and assisted with the implementation of their new online enrollment platform.

Of Further Note: The client has been so pleased with CBIZ's consulting services that they subsequently hired CBIZ's Compensation Consulting Services team to conduct a comprehensive compensation study and to rewrite their job descriptions.

CASE STUDY #2

Medical Plan Funding Type: Self-funded

Background: This case study is for a fire district with 300 employees. This client had been with their broker for over 8 years and had been self-funded during that period. They had become disillusioned with the lack of service they had been receiving from their broker and issued a formal Request for Proposal. CBIZ responded to the proposal and competed against five (5) other respondents and was subsequently awarded a contract in May 2022 following a rigorous review of responses and interview process.

Process: The client had made a change to their TPA on January 1, 2022, and was not interested in conducting a market check. Instead, the client had several outstanding service issues that needed prompt attention and wanted CBIZ to negotiate aggressively on their behalf for the January 2023 renewal.

Outcome: The CBIZ team, including CBIZ's Claims Advocate worked quickly to resolve outstanding claims and referral issues and most issues were resolved within two weeks with other being resolved shortly thereafter. Additionally, CBIZ was able to:

- Negotiate their overall medical plan renewal down to 1% from 9%,
- Assist the client with revamping their entire employee benefits consulting communications campaign for their 2023 open enrollment period which was well received by their employees.
- Revamp their medical/dental/vision plan's contribution strategy to be more efficient.
- Involve CBIZ's Onsite Clinic team to consult with the district on the implementation of an onsite nurse practitioner for their employees and dependents.

Of Further Note: The client has been so pleased with CBIZ's consulting services that they subsequently hired CBIZ's Compensation Consulting Services team to conduct a comprehensive compensation study and to rewrite their job descriptions.

CASE STUDY #3

Medical Plan Funding Type: Self-funded

Background: This case study is for a private, trade school with 600 employees. This client had been with their broker for over 27 years and had been self-funded for over 10 years. They had become disillusioned with their broker's lack of responsive service, innovation, and ability to provide them with meaningful strategies. Based on CBIZ's reputation for working with large, multi-site employers, the client contracted CBIZ along with another local broker for interviews. Following two (2) interviews, CBIZ was subsequently awarded a contract in June 2022.

Process: Initially the client was reticent to make any sweeping changes to their benefit plans. Following a review of their finances, their board of directors instructed the client to make meaningful changes to their medical insurance plan. CBIZ quickly began the process of reviewing the client's overall claims spend and particularly their prescription drug spend and found opportunities for significant cost savings.

Outcome: CBIZ recommendations resulted in the following:

- The client's medical stop-loss insurance carrier proposed a 24% increase; CBIZ marketed the stop-loss insurance contract and was able to secure a contract for 5% below the client's current rates and 29% below the initially proposed renewal. This resulted in a decrease in premiums of \$67,000
- CBIZ conducted a Pharmacy Benefit Manager (PBM) marketplace analysis and recommended a change in PBMs resulting in over \$360K savings.
- Combined Rx and Stop-loss insurance savings is expected to be over \$427,000.
- Assisted the client with revamping their entire employee benefits consulting communications campaign for their 2023 open enrollment period.
- Assisted the client with finding a new Wellness vendor at no additional cost.
- Assisted the client with developing and issuing a culture and benefits survey resulting in a remarkably high participation rate.
- Assisted the client with revamping their entire employee benefits consulting communications campaign for their 2023 open enrollment period which was well received by their employees.

CASE STUDIES/PRE-2022 CLIENTS

Below are five (5) additional, compelling case studies outlining the innovative solutions, processes, and results with which CBIZ proposed and implemented for some of our clients.

CASE STUDY #4a

Medical Plan Funding Type: Self-funded

Background: This case study is for a long-term, public school district client with 1,500 employees. Over the years, CBIZ had discussed a self-funding strategy with the district, but a combination of persistent high claims and rich benefits did not present itself as an ideal situation for self-funding.

Process: CBIZ had effectively worked to make meaningful modifications to the district's plan designs to make the premiums more affordable for the district and its employees. Through this process and circumstantial changes in the overall cost of claims, the opportunity for the consideration of self-funding became more tangible. As such, in 2016, CBIZ embarked on both a retrospective and prospective review of the district's claims cost profile to determine the viability of moving to self-funding.

Our prospective analysis indicated that it would be favorable for the district to move towards self-funding and as such, CBIZ worked closely with the district to issue and review responses to a Request for Proposal (RFP) for TPA, PBM, Stop-Loss insurance and Provider Network services. During this process, CBIZ also met with the following stakeholders to explain how self-funding worked, the merits of self-funding and the potential challenges with self-funding:

- Sr. Administration Team
- Employee Benefits Committee
- Bargaining Unit Employees
- Governing Board

Upon receiving and reviewing the results of the RFP, it was determined that moving the district into an unbundled self-funding strategy was in the best interest of the district and its employees. CBIZ worked closely with the district and the TPA through the installation process. Additionally, CBIZ was instrumental in securing a law firm familiar with setting up public sector trusts and CBIZ worked with the district and law firm to set up the district's Employee Benefits Trust including participation in the selection of the Board of Trustees.

Outcome: The move to self-funding has resulted in much lower overall costs for the district and since the implementation of their self-funded program two years ago, the district has realized a decrease in the costs of over \$1.7M and Per Employee Per Month (PEPM) cost decreasing an average of 7% per year cost during that same period.

CASE STUDY #4b

Background: This case study is for the aforementioned school district. In 2019, CBIZ's Managed Pharmacy Practice recommended to the district to consider the installation of a Specialty medication carve-out program. These programs carve out all specialty medications and cede the costs to both pharmaceutical companies and to philanthropic organizations. The district was interested and after reviewing several options, the district installed this program for their 2019/2020 plan year and since the plan was

implemented, the district's savings have exceeded \$4M have also resulted in the elimination of out-of-pocket expenses for employee participating in the program. There was also a beneficial impact on the district's stop-loss reinsurance premiums as these high-cost claims are no longer counted against the district's claims liability.

CBIZ worked collaboratively with the district's TPA, PBM and with the vendor to assist the district with the roll out of the program and to proactively communicate the functionality of the program to those employees or dependents to be affected by the change. The district has heard of little disruption to employees and any issues that arose were quickly addressed and resolved by the vendor.



CASE STUDY #5a

Medical Plan Funding Type: Self-funded

Background: The municipality in this case study with 282 employees, is also a long-term CBIZ client. For their 2017/2018 plan year, they implemented a Mexico network program which covers medical, prescription drug, dental and vision benefits. This was the year that they also hired CBIZ as their employee benefits consulting firm. This employer had been self-funded for over 25 years and was looking for a way to:

- a) Improve access to care for their employees.
- b) Provide a more convenient way for employees to access care.
- c) Lower the overall cost of care to the employees and to the City.

Process: After being introduced to the Mexico network vendor, the City implemented the program within their medical/Rx/dental/vision plans. CBIZ began working with both the municipality's carrier/TPA and clinic vendor to capture claims encounter data to measure how much cost avoidance the municipality has enjoyed since the inception of the clinic.

Outcome: The Mexico network plan has been a remarkable success for the municipality and has exceeded their desired goals and utilization expectations. CBIZ has been comparing the claims costs in Mexico to claims costs in the United States and the average cost avoidance saving per year averages over \$45,000.

CASE STUDY #5b

Medical Plan Funding Type: Self-funded

Background: This case study is for the aforementioned municipality. For their 2021/2022 plan year CBIZ did a Pharmacy Benefit Manager (PBM) cost review and based on this review, CBIZ made a recommendation for a change in PBM. In addition to reviewing the PBM offering CBIZ also looked at a specialty Rx carve-out option.

Projected Outcome: Based on CBIZ's review and recommendations, the municipality elected to change their PBM vendor for the 2021/2022 plan year. The costs savings for the plan year exceeded \$240K.

Of Further Note: Since hiring CBIZ, this client has experienced a NEGATIVE, Per Employee Per Month cost trend of -3.8%.

CASE STUDY #6

Medical Plan Funding Type: Self-funded

Background: The public school district (7,000 employees) in this case study hired CBIZ as their employee benefits consultants in September 2019. The district had been involved with a large, public-sector trust for several years and the trust has acted as the districts' de facto employee benefits consultants. The district did not feel that the Trust had acted objectively in their consulting with the district, so the district sought to hire an outside consultant to assist them with the strategy development and execution strategies. The district issued a benefits consulting RFP and after the thorough review and vetting of several submissions by qualified consulting agencies, the district awarded the contract to CBIZ.

Process: Shortly after being hired, CBIZ was tasked to assist the district with the development, issuance, and review of a combined TPA and PBM RFP. CBIZ worked quickly with the district to issue the RFP and to assist with all aspects of the review process including meeting with the district's Purchasing department, HR/Benefits department, Finance department, the selection and review committee, the Employee Benefits Trust, and the Governing Board.

Outcome: Throughout the RFP review process, CBIZ utilized the services of its in-house analytical and actuarial team and its in-house Managed Pharmacy Practice team to review the costs and savings potential of the submitted RFPs. The structure of the RFP lead to the district receiving competitive TPA and PBM quotes which should result in a cost savings to the district of almost \$2M per year. A good portion of those savings will come from the placement of the district's PBM services with a national PBM cooperative which will minimize the district's costs through the maximization of rebates. CBIZ's knowledge and experience with PBM cooperatives enabled CBIZ to provide the district with an in-depth and comprehensive analysis of the submitted cooperative program's response and quote. CBIZ's consultation throughout the process resulted in a recommendation by the selection and review committee and will result in significant cost savings for the district.

Of Further Note: CBIZ recently completed the district's pharmacy savings analysis and comparison and the plan saw a decrease in pharmacy spend of over \$1.2M which equates to a -12.7% change cost. Annual pharmacy trend increases are estimated to be +7.4% so factoring the upward trend with the decrease percentage over this period, the district's costs were lowered by -20.1%.

CASE STUDY #7a

Medical Plan Funding Type: Self-funded

Background: The municipality in this case study (289 employees) is also a long-term CBIZ client. In 2016, the municipality began researching the possibility of installing an onsite clinic for their employees and dependents. By that point, they had been self-funded for X years and wanted to use the clinic to:

- a. Improve access to care for their employees.
- b. Provide a more convenient way for employees to access care.
- c. Lower the overall cost of care to the employees and to the Town.
- d. Utilize the services of the clinic to assist with the Town's wellness efforts and strategies.
- e. Utilize the services of the clinic to assist with outside medical provider referrals and to provide some population management and care outreach assistance.

Process: After reviewing several vendor options, the town launched their onsite clinic in 2017. CBIZ began working with both the municipality's carrier/TPA and clinic vendor to capture claims encounter data to measure how much cost avoidance the municipality has enjoyed since the inception of the clinic. Additionally, CBIZ's in-house Wellbeing Account Executive has work with the municipality, its clinic manager and wellness vendor to develop wellness campaigns to direct employees and their dependents to the clinic. Since the launch of the program, the Town has also partnered up with a fire district to share the clinic with their employees and dependents.

Outcome: The onsite clinic has been an immense success for the municipality and has exceeded their desired goals and utilization expectations. Additionally, CBIZ was able to calculate that the municipality has had an overall net (excluding operation expenses) cost avoidance averages of more than \$200K per year.

CASE STUDY #7b

Background: This case study is for the aforementioned municipality. The municipality had been facing regularly increasing medical plan costs and for the 2022/2023 plan year, the municipality agreed to allow CBIZ to conduct a Pharmacy Benefit Manager marketplace review,

Projected Outcome: CBIZ has been able to provide several cost savings options and expects to lower this client's cost by over \$100K through changes to their Pharmacy Benefit Manager arrangement and without a PBM change.

CASE STUDY #8 - Arizona Healthcare Reciprocal Insurance Captive (AHRIC)

Additionally, in 2015, CBIZ formed its own self-funded, captive insurance company, the Arizona Healthcare Reciprocal Insurance Captive (AHRIC) for non-profit agencies which has performed exceptionally well since its inception. AHRIC is made up of 13 non-profit agencies with over 5,000 covered lives (including Marana Health Center) and since its launch, its members average renewal increase has been 2.7%, has surpluses in five (5) out of six (6) years and has paid dividends to its members twice.

We believe that these demonstrations of innovation highlights our ability to provide our clients with creative, innovative, and long-term cost savings solutions.





SECTION 9

CBIZ CLIENT TESTIMONIALS



ISO CLASS 1 ★ INTERNATIONALLY ACCREDITED
13535 N. Marana Main St. | Marana, AZ 85653
(520) 887-1010 | www.nwfdaz.gov
@NorthwestFire | /NorthwestFireDistrict

September 8, 2023

RE: CBIZ Employee Benefits

To Whom It May Concern:

After 10 years with same benefit broker, Northwest Fire District made the decision to solicit a new benefits broker. Through the District's Request for Proposal (RFP) process, CBIZ along with several other benefits brokers responded the RFP. The District's selection committee reviewed the responses, and vetted brokers with a final interview process. The selection committee recommended CBIZ as the District's broker to the Governing Board.

The District has been working with CBIZ for a little over a year now, and we have been very pleased with their knowledge and level of service they provide. The timing of CBIZ becoming our broker happened to be right after we switched insurance carriers with our former broker. The District was having several issues with continuity of care and a smooth transition for our employees, due a number of things not being performed by the former broker. CBIZ stepped into their new role as broker for the District, and was able to assist several of our employees and work with the new insurance carrier to achieve successful outcomes for the employees. The relationship CBIZ has with our carriers helped us get through a few challenges we were trying to navigate for employees.

The District was looking for a broker that aligned with our mission as an organization. We are always looking for new solutions to provide our employees with the best care possible. We recently hired a Nurse Practitioner on staff, and opened a Family Care Center for employees and their dependents on our insurance plan. CBIZ attended and facilitated several meetings to help us step up administrative and clinic side of the care center. The response from staff has been positive, and the number of people taking advantage what the care center can offer grows each month.

CBIZ meets with staff on a regular basis, and provides detailed easy to understand claims cost performance by both plan year and fiscal year. During our annual renewal process, they work very well with our carriers and work to negotiate better stop loss insurance rates, and have been successful in keeping our fixed cost increases low. CBIZ presents renewal information to our labor union in a way that is easy for them to understand all the aspects of being self-insured. We have received very good feedback from our labor union on the information CBIZ provides to them.

The District is very pleased with the highly responsive, transparent, and involved level of service we have received from the CBIZ team.

If you have any questions, please don't hesitate to contact me at 520-887-1010 x 2915, or at ksotomayor@nwfdaz.gov.

Sincerely,

Kim Sotomayor
Business Services Director/CFO



*Town of Oro Valley
Human Resources Department*

To whom it may concern:

Please accept this letter of reference for CBIZ as our Employee Benefits Consultant. I have worked directly with CBIZ over the past two years as the Human Resources Analyst – Benefits for the Town of Oro Valley, and have fifteen years of Human Resources experience with a focus on benefits and employee wellness. Due to CBIZ's high caliber guidance and support, the Town has had a strong relationship with CBIZ over many years and was a clear winner the last time the Town went out to bid.

The entire CBIZ team that we work with is highly knowledgeable and responsive. They have been able to listen closely to the needs of the Town and provide customized solutions and plan designs to stay within our budget and meet employee needs. They are always on top of what needs to be done and ready to assist with questions and planning. They provide regular detailed reporting and work closely with our insurance carriers to get the information we need to make plan decisions. When we have questions about a plan detail or compliance issue, they are always quick to get a trustworthy answer.

CBIZ's guidance in transitioning the Town to a self-insured medical plan several years ago has helped save the Town a significant amount of money. Their ongoing analysis and plan design support continues to assist in keeping medical and pharmacy cost increases manageable and often below market.

I have worked with the CBIZ team on insurance RFPs and find they are very thorough in their analysis and stay involved to help with the transition to a new carrier. Every year, they are able to listen to the varying needs of our Town Manager, our CFO and the HR Department, and help strategize for the upcoming plan years. They have provided excellent support throughout our annual Open Enrollment process, including planning timelines, detailed premium analysis and tables and professional communication tools. CBIZ has also provided guidance, tools and resources to advance our well-being programs. Our particular contract also includes a CBIZ claims advocate whom our employees are very pleased with.

I would truly highly recommend their services and believe them to be an excellent choice. I would be happy to answer any specific questions you have during your RFP process.

Sincerely,

Andrea Lightfoot Bisson
Human Resources Analyst
alightfootbisson@orovalleyaz.gov
(520) 229-4752

Oro Valley, it's in our nature.

CITY OF NOGALES



August 7, 2020

Re: CBIZ Employee Benefits

To Whom It May Concern:

After more than 20 years with the same insurance broker, the City of Nogales's Employee Benefits Trust (EBT) made the decision to seek new insurance consulting representation. CBIZ, along with several other brokers responded to the City of Nogales's Request for Benefits Broker Proposal. The City's selection process included a thorough review of responses, vetting and interviews with the responding brokers. At the end of the process, the EBT selected CBIZ as our broker.

The EBT has now been with CBIZ for over 3 ½ years and we have been very pleased with the level of service they provide. They have worked very well with our carriers and vendors and have been able to negotiate better stop-loss insurance rates and better rebate terms with our Pharmacy Benefit Manager resulting in lower costs for the EBT.

Early on in their engagement with the EBT, CBIZ began attending monthly meetings with the EBT and providing us with in-depth and easy to understand claims cost performance reporting that dovetails well with the financial reports provided by our Third Party Administrator. Annually, CBIZ also presents a wrap up of our plan's annual performance to our City Council and we have received very good feedback from the Council on the information provided by CBIZ.

As our brokers, CBIZ also began working with our Wellness Committee to develop better engagement strategies with our employees. With CBIZ's assistance, consulting and guidance, our Wellness Committee has been able to provide a more impactful wellness program to our employees and our employees now see the value of our wellness program. We continue to see more and more employee engagement each year and this is resulting in better claims performance as well. Our CBIZ wellness consultant has also worked with the EBT at securing vendors for our annual health fair, at coordinating our flu shot clinic and at setting up other onsite healthcare events.

We are very pleased with the highly responsive and involved service that we have received from CBIZ and the amount of effort they put into helping our EBT to execute our employee benefits strategies.

If you have any questions, please contact me at, (520) 285-5782, office/ (520) 980-5233, cell or at, mbachelier@nogalesaz.gov.

Sincerely,

A handwritten signature in blue ink that reads "Marcel Bachelier".

Marcel Bachelier
City of Nogales
Employee Benefits Trust Chairman
Parks and Recreation Director

MAYOR
BOB TESO

VICE MAYOR
HERMAN LOPEZ

ACTING MAYOR
PAUL DIAZ

COUNCIL MEMBERS
AKANNI OYEBOLA
RITA ROGERS
ANITA ROMERO
ROBERT ROMERO



INTERIM CITY MANAGER
VERONICA B. MORENO

1601 SOUTH 6TH AVENUE
SOUTH TUCSON, ARIZONA 85713
(520) 792-2424
FAX (520) 628-9619

August 5, 2020

Re: CBIZ Employee Benefits

To Whom It May Concern:

The City of South Tucson has been working with CBIZ for over 20 years. During this time, CBIZ has always worked diligently to provide the City and our employees with an exceptionally high level of service. CBIZ has been with us through several financial downturns and hardships and they have always been willing and able to provide the City with creative and cost effective solutions to meet our budgetary and benefits needs and goals. Our partnership with CBIZ enables the City to continue to offer our employees an affordable and comprehensive benefits package and we always feel that CBIZ is always looking out for our best interests and we value them as our trusted advisors.

We sincerely recommend that you consider them as you review your employee benefits consulting options as we feel that you will be pleased with their experience and knowledge, their innovative solutions and approaches and with the dedication to service that they will provide your organization.

If you have any questions about our experiences with CBIZ, please don't hesitate to contact me at, (520) 792-2424 Ext 312, or at vmoreno@southtucson.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Veronica Moreno", is placed above the printed name.

Veronica Moreno
Interim City Manager / City Clerk



August 5, 2020

Re: CBIZ Employee Benefits

To Whom It May Concern:

Pima County Government has a long-standing relationship with CBIZ dating back to 2000. CBIZ primarily provides the County with consulting on all aspects of its self-funded medical insurance plan.

When the County began its relationship with CBIZ, our medical plan was fully-insured. The County's long-term strategy had been to move from a fully-insured to a self-funded arrangement and worked closely with CBIZ to achieve that goal in 2013. CBIZ worked closely with the County to execute that strategy and with CBIZ's assistance, the County has been able to achieve excellent financial results through self-funding.

Throughout their tenure with the County, CBIZ has provided the County with innovative approaches and with impactful consulting and guidance. The County has counted on CBIZ to assist with the following:

- Implementation of a self-funded medical plan
- Implementing a High Deductible Health Plan/Health Savings Account strategy
- Removing retiree enrollment from the active employee plan
- Issuing RFPs for Medical, Third Party Administration and Pharmacy Benefit Management Services
- In-depth review of contracts
- Negotiation of better terms and rates with our vendors and carriers
- Providing in-depth reporting, analytics and actuarial services
- Providing in-depth pharmacy benefits consulting
- Providing wellness consulting and support
- Providing compliance assistance and education
- Effectively engaging with our Employee Benefits Committee, Meet and Confer Committee, Employee Benefits Trust and Governing Board

The County has enjoyed our long-term relationship with CBIZ and values the expertise and service they provide and their dedication towards assisting the County with meeting its goals, objectives and obligations.

If you have any questions about our engagement with CBIZ, please call me at (520)740-8006 or email me at gayl.zambo@pima.gov.

Sincerely,

Gayl Zambo
Human Resources Division Manager



Sunnyside Unified School District
Human Resources and Benefits Department
2238 East Ginter Road • Tucson, Arizona 85706
Phone: (520) 545-2003 Fax: (520) 545-2023
Internet: www.susd12.org

August 6, 2020

Re: CBIZ Employee Benefits

To Whom It May Concern:

Sunnyside Unified School District began in its relationship with CBIZ Employee Benefits in 2013. Since that time, we have been very pleased with their consulting services. They have supported the District within every aspect of our employee benefits offerings and have worked tirelessly to ensure that they are meeting our expectations and are assisting the District in meeting its obligations to our employees.

In 2017/2018, CBIZ was instrumental in guiding the District towards the self-funding of our medical insurance plan. Throughout this process, they met with a variety of stakeholders within our District to provide them valuable education and information about self-funding. These stakeholders included our Employee Benefits Committee, our Interest Based Bargaining Teams, our Human Resources and Business staff, Superintendent and Governing Board. CBIZ's presentations were clear and well received and opened up the opportunity for the District to move towards self-funding with important buy-in from our stakeholders.

CBIZ was also very instrumental in helping the District to craft a self-funded services RFP and at assisting the District with reviewing the results of the RFP responses, qualifying the responses and assisting the District with its selection of carriers and vendors. The District also relied on CBIZ to assist us with the installation of our Employee Benefits Trust. They have continued to provide meaningful and impactful support to our Trust by providing them and the District with concise claims reporting and financial projections. Our move to self-funding has resulted in substantial savings to the District and its employees and we credit CBIZ's team of consultants including their pharmacy, actuarial, and wellness team members for helping the District to achieve those results.

CBIZ also continues to bring innovative and cost savings strategies to the District which have resulted in cost savings to both the District and its employees. A recent example of this is the implementation of a specialty medication carve-out program in 2019 which resulted in a \$600K cost saving to the District and which protected our employees from costly out-of-pocket expenses.

We highly value the professional, responsive and innovative service that CBIZ provides the District and look forward to a continued relationship with them.

If you have any questions about the District's experiences with CBIZ, please don't hesitate to contact me at, (520) 545-2039 or at, laurae@susd12.org.

Sincerely,

A handwritten signature in black ink that reads "Laura Emslie".

Laura Emslie
Director of Human Resources

Exhibit B

Scope of Work

EXHIBIT B – SCOPE OF WORK

I. Project Overview

The City seeks statement of qualifications/proposals from experienced and qualified firms to provide broker-of-record and consulting services for the City's employee benefits programs.

II. Scope of Services

The City seeks qualifications from experienced, compliant with applicable and licensing for the profession, and otherwise qualified firms to provide broker-of-record and consulting services for the City's employee benefits programs including, but not limited to, the City's following programs:

- Health Insurance (*US/Mexico Plan & Mexico Only Plan*)
- Voluntary Dental Insurance (*US/Mexico Plan & Mexico Only Plan*)
- Voluntary Vision Insurance
- Life and Accidental Death & Dismemberment (AD&D) Insurance
- Short-Term and Long
- Section 125 Flexible Spending Accounts
- COBRA - third party administration
- FMLA administration
- Wellness Plan
- Telemedicine
- Employee Assistance Program
- Voluntary Supplemental coverage
- Stop Loss Insurance
- Other Ancillary Benefits as Deemed Appropriate

The broker/consultant selected will provide a full range of consulting and brokerage services in cooperation with the City staff and management. The broker/consultant will assist the City, by performing a full range of services related to the design, implementation, maintenance, communication, and improvement of the City of San Luis group medical, dental, vision, STD/LTD, life insurance coverage and other various benefits as listed above. The broker/consultant will be expected to provide services including, but not limited to, the following:

- **ADMINISTERING ALL GROUP INSURANCE PLANS, RESPONDING TO QUESTIONS FROM AND PROVIDING INFORMATION TO STAFF, AND PROVIDING OTHER CONSULTING SERVICES DURING THE COURSE OF THE PLAN YEAR.**
- **REVIEWING CLAIMS EXPERIENCE, CLAIM SERVICE, AND CLAIM ADMINISTRATION TO ENSURE MAXIMUM BENEFIT TO THE CITY.**
- **DETERMINING AND RECOMMENDING THE MOST ECONOMICAL FUNDING METHODS FOR THE BENEFIT PROGRAMS.**

- **REPRESENTING THE CITY IN ALL NEGOTIATIONS WITH PROVIDERS ON ALL ISSUES INCLUDING THOSE RELATED TO PREMIUMS, BENEFIT LEVELS, PLAN DESIGN, AND SPECIAL TERMS AND CONDITIONS.**
- **MEETING WITH AND PROVIDING REPORTS TO VARIOUS CITY REPRESENTATIVES INCLUDING THE CITY MANAGER, HUMAN RESOURCES DIRECTOR, FINANCE DIRECTOR, AND EMPLOYEE BENEFITS TRUST.**
- **RECOMMENDING ITEMS TO BRING TO THE BOARD OF TRUSTEES' MEETINGS SUCH AS ADDING OR CHANGING PROGRAMS, TRENDS IN CLAIMS. THE BOARD MEETS AT LEAST FOUR TIMES PER YEAR FOR STAFF TO REPORT ON THE TRUST FUND BALANCE AND OTHER TOPICS THE BROKER/CONSULTANT MAY PRESENT AFTER CONSULTATION WITH STAFF. IT IS EXPECTED BROKER/CONSULTANT COMPLY WITH THE BOARD'S DEADLINES, ATTEND TRUST MEETINGS AS NEEDED, AND ADHERE TO THE OPEN MEETING LAW AND BASIC ROBERT'S RULES OF CONDUCT DURING BOARD MEETINGS**
- **ATTENDING THE CITY COUNCIL'S ANNUAL BUDGET MEETING IN APRIL TO EXPLAIN THE UPCOMING PLAN AND FUNDING NEEDED FOR THE PLAN WHICH STARTS ON JULY 1.**
- **IMPLEMENTATION AND FOR THE EMPLOYEES COMMUNICATION OF NEW PROGRAMS OR CHANGES TO EXISTING PROGRAMS (WRITTEN MATERIAL IN ENGLISH & SPANISH), THAT WILL INCLUDE ATTENDING AND PRESENTING INFORMATION AT OPEN ENROLLMENT MEETINGS.**
- **RESEARCHING AND ADVISING THE CITY OF ANY NEW DEVELOPMENTS IN THE STATE AND FEDERAL LAW AND EMPLOYEE BENEFIT PROGRAMS ON AN ONGOING BASIS.**
- **PROVIDING TIMELY COMPLIANCE WITH STATE AND FEDERAL LAWS AND REGULATIONS EXISTING AND AS AMENDMENTS BECOME EFFECTIVE RELATED TO EMPLOYEE BENEFITS AND TO SELF-FUNDED GROUPS IN PARTICULAR.**
- **WORKING WITH A MEXICAN NETWORK PROVIDER INCLUDING BUT NOT LIMITED TO ANALYZING EQUIVALENCES AS NECESSARY TO COMPLY WITH THE ACA AND OTHER LAWS AND REGULATIONS, SEEKING POSSIBILITIES FOR EXPANSION OF THE NETWORK.**
- **MONITORING LAW AND REGULATION FOR CHANGES RELATED TO HEALTH BENEFITS FOR POLICE, FIREFIGHTERS AND AMBULANCE SERVICES PERSONNEL.**

- **PREPARING BID SPECIFICATIONS AND SOLICITING PROPOSALS FROM INSURANCE MARKETS WHICH SPECIALIZE IN GROUP INSURANCE PLANS AS NEEDED. EVALUATE BIDS AND BIDDERS, INCLUDING ADMINISTRATION, CLAIM PAYMENT PROCEDURES, CUSTOMER SERVICE, NETWORK, RESERVE ESTABLISHMENT POLICIES, FINANCIAL SOUNDNESS, AND IDENTIFYING THE MOST COST-BENEFICIAL PACKAGE FROM AMONG THE VARIOUS BIDDERS.**
- **INTERFACING WITH INSURANCE CARRIERS AS NEEDED TO ASSIST THE CITY IN THE RESOLUTION OF PROBLEMS ASSOCIATED WITH THE BENEFIT PROGRAMS.**
- **REVIEWING EXISTING PROGRAMS AND IDENTIFICATION OF RECOMMENDATIONS FOR CHANGES IN PLAN PROVISIONS, ALTERNATIVE DELIVERY SYSTEMS, FUNDING ALTERNATIVES, PREMIUM COST-SHARING AND OTHER AREAS, AS APPROPRIATE.**
- **PROVIDING COMPLETE COBRA ADMINISTRATIVE SERVICES.**
- **PROVIDING EXCELLENT CUSTOMER SERVICE, INCLUDING BUT NOT LIMITED TO TAKING TIME TO LEARN THE ISSUE AT HAND AND PROVIDING APPROPRIATE SOLUTIONS OR OPTIONS.**
- **RESPONDING PROMPTLY TO ALL COMMUNICATIONS FROM THE STAFF AND MANAGEMENT. ADDRESS QUESTIONS, CONCERNS, AND REPORTS OF ISSUES DILIGENTLY AND EXPEDITIOUSLY. PERSONAL SERVICE DIRECTLY WITH THE INDEPENDENT PROFESSIONAL BROKER IS EXPECTED. CALL CENTER SERVICE IS UNACCEPTABLE.**

III. Broker experience and qualifications

The successful broker shall perform the services necessary to evaluate current insurance coverages and services and potentially replace insurance coverage if it's to the benefit of the City.

A. Broker's experience & qualifications

Demonstrate the Broker's knowledge and experience relative to the terms identified under the Scope of Work. Include a list of similar services provided and a description of the Broker's general organization and names of key personnel, indicating the depth and quality of experience.

B. Identification and organization of the proposed team

Please provide the number of licensed employee benefits staff with five (5) years of commercial lines experience, for the following categories:

1. Brokers, and
2. Other professional staff.

C. Additional Information Requested:

1. List Arizona public entity accounts, dates of service, including the name and phone number of the primary contact for similar projects done by the personnel to be involved in these projects.
2. Discuss any additional services the Consultant normally offers in conjunction with providing the lines of insurance that are referenced in the RFQ.

Exhibit C-1

Negotiated Fee Schedule

Exhibit C-1 Fee Schedule

CBIZ-City of San Luis Employees Benefits Trust

CBIZ's Original & Submitted Annual Fee Proposal		
Contract Years 1 and 2	Contract Years 3 and 4	Contract Year 5
\$96,000 per year	\$102,000 per year	\$108,000 per year

Lump Sum \$48,000 for January 2024-June 2024, calculated at \$8,000 per month									
CBIZ Monthly Billed Fees									
Contract Year 1		Contract Year 2		Contract Year 3		Extension Contract Year 4		Extension Contract Year 5	
Jul-24	\$8,000	Jul-25	\$8,000	Jul-26	\$8,500	Jul-27	\$8,500	Jul-28	\$9,000
Aug-24	\$8,000	Aug-25	\$8,000	Aug-26	\$8,500	Aug-27	\$8,500	Aug-28	\$9,000
Sep-24	\$8,000	Sep-25	\$8,000	Sep-26	\$8,500	Sep-27	\$8,500	Sep-28	\$9,000
Oct-24	\$8,000	Oct-25	\$8,000	Oct-26	\$8,500	Oct-27	\$8,500	Oct-28	\$9,000
Nov-24	\$8,000	Nov-25	\$8,000	Nov-26	\$8,500	Nov-27	\$8,500	Nov-28	\$9,000
Dec-24	\$8,000	Dec-25	\$8,000	Dec-26	\$8,500	Dec-27	\$8,500	Dec-28	\$9,000
Jan-25	\$8,000	Jan-26	\$8,000	Jan-27	\$8,500	Jan-28	\$8,500	Jan-29	\$9,000
Feb-25	\$8,000	Feb-26	\$8,000	Feb-27	\$8,500	Feb-28	\$8,500	Feb-29	\$9,000
Mar-25	\$8,000	Mar-26	\$8,000	Mar-27	\$8,500	Mar-28	\$8,500	Mar-29	\$9,000
Apr-25	\$8,000	Apr-26	\$8,000	Apr-27	\$8,500	Apr-28	\$8,500	Apr-29	\$9,000
May-25	\$8,000	May-26	\$8,000	May-27	\$8,500	May-28	\$8,500	May-29	\$9,000
Jun-25	\$8,000	Jun-26	\$8,000	Jun-27	\$8,500	Jun-28	\$8,500	Jun-29	\$9,000
Totals by Period	\$96,000		\$96,000		\$102,000		\$102,000		\$108,000

\$504,000 Grand Total