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AGREEMENT BETWEEN THE SOUTHWEST FLORIDA WATER MANAGEMENT DISTRICT AND RISK MANAGEMENT ASSOCIATES, INC. DBA PUBLIC RISK INSURANCE ADVISORS FOR INSURANCE BROKER SERVICES FOR HEALTH, PROPERTY AND CASUALTY, AND WORKERS' COMPENSATION

THIS AGREEMENT is made and entered into by and between the SOUTHWEST FLORIDA WATER MANAGEMENT DISTRICT, a public corporation of the State of Florida, whose address is 2379 Broad Street, Brooksville, Florida 34604-6899, hereinafter referred to as the "DISTRICT," and Risk Management Associates, Inc. dba Public Risk Insurance Advisors, a private corporation, whose principal address is 220 S. Ridgewood Avenue, Suite 210, Daytona Beach, Florida 32114, hereinafter referred to as the "BROKER."

WITNESSETH:

WHEREAS, the DISTRICT desires to engage the BROKER to assist the DISTRICT with the development of a strategic plan for the design, negotiation, implementation, analysis, monitoring, measurement and administration of the most cost-effective insurance programs, hereinafter referred to as the "PROJECT"; and

WHEREAS, the BROKER represents that it possesses the requisite skills, knowledge, expertise and resources and agrees to provide the desired services to the DISTRICT; and

WHEREAS, the DISTRICT and the BROKER have agreed on the type and extent of services to be rendered by the BROKER and the amount and method of compensation to be paid by the DISTRICT to the BROKER for services rendered.

NOW THEREFORE, the DISTRICT and the BROKER, in consideration of the mutual terms, covenants and conditions set forth herein, agree as follows:

1. INDEPENDENT CONTRACTOR.

   The BROKER will perform as an Independent Contractor and not as an employee, representative or agent of the DISTRICT. In accordance with the status of an Independent Consultant, the BROKER covenants and agrees that the BROKER will conduct business in a manner consistent with that status, that the BROKER will not claim to be an officer or employee of the DISTRICT for any right or privilege applicable to an officer or employee of the DISTRICT, including, but not limited to: worker's compensation coverage; unemployment insurance benefits; social security coverage; or retirement membership.

2. PROJECT MANAGER AND NOTICES.

   Each party hereby designates the employee set forth below as its respective Project Manager. Project Managers will assist with PROJECT coordination and will be each

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party's prime contact person. Notices and reports will be sent to the attention of each party's Project Manager by U.S. mail, postage paid, by nationally recognized overnight courier, or personally to the parties' addresses as set forth in the introductory paragraph of this Agreement. Notice is effective upon receipt.

Project Manager for the DISTRICT:
Courtney Marion
Southwest Florida Water Management District
2379 Broad Street
Brooksville, Florida 34604-6899

Project Manager for the BROKER:
Mathew Montgomery
Public Risk Insurance Advisors
220 S. Ridgewood Avenue, Suite 210
Daytona Beach, Florida 32114

Any changes to the above representatives or addresses must be provided to the other party in writing.

2.1. The DISTRICT'S Project Manager is authorized to approve requests to extend a PROJECT task deadline set forth in this Agreement. Such approval must be in writing, explain the reason for the extension and be signed by the Project Manager and his or her Bureau Chief, or Director if the Bureau Chief is the Project Manager, unless the DISTRICT'S Signature Authority provides otherwise. The DISTRICT'S Signature Authority supersedes the approval requirements provided in this provision. The DISTRICT'S Project Manager is not authorized to approve any time extension, which will result in an increased cost to the DISTRICT, or which will exceed the expiration date set forth in Paragraph 5, Contract Period.

2.2. The DISTRICT'S Project Manager is authorized to adjust a non-fixed price line item amount contained in the Compensation Plan set forth in Exhibit "B." The authorization must be in writing, explain the reason for the adjustment, and be signed by DISTRICT staff in accordance with the DISTRICT'S Signature Authority. The DISTRICT'S Project Manager is not authorized to a) make changes to the Nature of Services Required as set forth in Exhibit "A", or b) change any aspects of the Compensation Plan set forth in Exhibit "B" except as expressly authorized in this Subparagraph.

3. SCOPE OF WORK.

Upon receipt of a written notice to proceed from the DISTRICT, the BROKER agrees to timely perform the requested services in accordance with the Nature of Services Required set forth in Exhibit "A," the BROKER'S response to Invitation to Negotiate (ITN) 1911 pertaining to the BROKER'S provision of awarded services without regard to proposed compensation contained therein, and the Compensation Plan set forth in Exhibit "B." Any changes to this Scope of Work, except as otherwise authorized in this Agreement, must be mutually agreed to in a formal written amendment approved by the DISTRICT and the BROKER prior to being performed by the BROKER, subject to the provisions of Paragraph 4, Compensation.

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3.1. The parties agree that time is of the essence in the performance of each obligation under this Agreement.

3.2. The DISTRICT and the BROKER hereby recognize the specialized expertise of the Implementation Team Members as identified in the BROKER'S response to ITN 1911. Both parties further agree that any changes to the Implementation Team would require prior written approval from the DISTRICT. Such approval must be in writing, explain the reason for the change and be signed by the DISTRICT'S Project Manager and his or her Bureau Chief, or Director if the Bureau Chief is the Project Manager.

3.3. Supplemental Services, if required, shall be authorized by a Purchase Order (PO). The PO shall detail the scope of work to be performed, deliverables, performance schedule and cost.

4. COMPENSATION.

The DISTRICT agrees to pay the BROKER for all services provided in Exhibit "A," Nature of Services Required in accordance with the Compensation Plan set forth in Exhibit "B" and the Local Government Prompt Payment Act, Part VII of Chapter 218, Florida Statutes (F.S.), upon receipt of a proper invoice, as defined in subparagraph 4.2 of this Agreement for work satisfactorily performed by the BROKER. Should this Agreement terminate before the DISTRICT enters into contracts with insurance providers, the BROKER shall not be entitled to any compensation. Invoices shall be submitted by the BROKER to the DISTRICT electronically at invoices@WaterMatters.org, or at the following address:

Accounts Payable Section
Southwest Florida Water Management District
Post Office Box 1166
Brooksville, Florida 34605-1166

4.1. The DISTRICT'S performance and payment pursuant to this Agreement are contingent upon the DISTRICT'S Governing Board appropriating funds in its approved budget for the PROJECT in each Fiscal Year of this Agreement.

4.2. All invoices must include the following information: (1) BROKER'S name, address and phone number (include remit address, if different than principal address in the introductory paragraph of this Agreement); (2) BROKER'S invoice number and date of invoice; (3) DISTRICT Agreement number; (4) Dates of service; (5) BROKER'S Project Manager; (6) DISTRICT'S Project Manager; (7) Supporting documentation, necessary to satisfy auditing purposes, for cost and project completion (based upon the Compensation Plan and performance schedule in this Agreement); and (8) Any additional information that may be required under a PO. The final invoice will include information relating to the amount of expenditures made to disadvantaged business enterprises (based on the requirements contained in Paragraph 24). Invoices that do not conform with this paragraph will not be considered a proper invoice.

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4.3. If an invoice does not meet the requirements of this Agreement, the DISTRICT'S Project Manager, after consultation with his or her Bureau Chief, will notify the BROKER in writing that the invoice is improper and indicate what corrective action on the part of the BROKER is needed to make the invoice proper. If a corrected invoice is provided to the DISTRICT that meets the requirements of this Agreement, the invoice will be paid within forty-five (45) days after the date the corrected invoice is received by the DISTRICT.

4.4. In the event any dispute or disagreement arises during the course of the PROJECT, including those concerning whether a deliverable should be approved by the DISTRICT, the BROKER will continue to perform the PROJECT work in accordance with the DISTRICT'S instructions and may claim additional compensation. The BROKER is under a duty to seek clarification and resolution of any issue, discrepancy, or dispute by providing the details and basis of the dispute with a request for additional information, additional compensation, or schedule adjustment, as appropriate, to the DISTRICT'S Project Manager no later than ten (10) days after the precipitating event. If not resolved by the Project Manager, in consultation with his or her Bureau Chief, the dispute will be forwarded to the Executive Director. The Executive Director in consultation with the DISTRICT'S Office of General Counsel will issue a final determination. The BROKER will proceed with the PROJECT in accordance with the DISTRICT'S determination; however, such continuation of work will not waive the BROKER'S position regarding the matter in dispute. No PROJECT work will be delayed or postponed pending resolution of any disputes or disagreements.

4.5. By October 5th of each year of the Agreement, the BROKER must provide the following documentation to the DISTRICT for all services performed through September 30th: i) invoices for completed, accepted and billable tasks, ii) an estimate of the dollar value of services performed, but not yet billable.

4.6. The Compensation Plan includes any travel expenses which may be authorized under this Agreement

4.7. Each BROKER invoice must include the following certification, and the BROKER hereby delegates authority by virtue of this Agreement to its Project Manager to affirm said certification:

> "I hereby certify that the costs requested for payment, as represented in this invoice, are directly related to the performance under the Broker Services agreement between the Southwest Florida Water Management District and Risk Management Associates, Inc. dba Public Risk Insurance Advisors (Agreement No. 20CN0002898), are allowable, allocable, properly documented, and are in accordance with the approved Compensation Plan."

4.8. The DISTRICT may, in addition to other remedies available at law or equity, retain such monies from amounts due the BROKER as may be necessary to satisfy any claim for damages, penalties, costs and the like asserted by or against the DISTRICT. The DISTRICT may set off any liability or other obligation of the

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BROKER or its affiliates to the DISTRICT against any payments due the BROKER under any contract with the DISTRICT. This paragraph will survive the expiration or termination of this Agreement.

5. CONTRACT PERIOD.

This Agreement will be effective January 1, 2020 and will remain in effect through January 1, 2022, unless terminated, pursuant to Paragraphs 14 and 15 below, or as amended in writing by the parties.

6. PROJECT RECORDS AND DOCUMENTS.

6.1. The BROKER, upon request, shall permit the DISTRICT to examine or audit all PROJECT related records and documents during or following completion of the PROJECT at no cost to the DISTRICT. These records shall be available at all reasonable times for inspection, review, or audit. "Reasonable" shall be construed according to circumstances, but ordinarily shall mean normal business hours of 8:00 a.m. to 5:00 p.m., local time, Monday through Friday. In the event any work is subcontracted, the BROKER shall similarly require each subcontractor to maintain and allow access to such records for inspection, review, or audit purposes. Payments made to the BROKER under this Agreement shall be reduced for amounts found to be not allowable under this Agreement by an audit. If an audit is undertaken by the DISTRICT, all required records shall be maintained until the audit has been completed and all questions arising from it are resolved. The BROKER shall maintain all such records and documents for at least five (5) years following completion of this Agreement. If an audit has been initiated and audit findings have not been resolved at the end of the five (5) years, the records shall be retained until resolution of the audit findings, which would include an audit follow-up by the inspector general if the findings result from an external auditor, or any litigation. The BROKER and any subcontractors understand and will comply with their duty, pursuant to Section 20.055(5), F.S., to cooperate with the inspector general in any investigation, audit, inspection, review, or hearing.

6.2. Each party shall allow public access to PROJECT documents and materials made or received by either party in accordance with the Public Records Act, Chapter 119, F.S.to the extent required by Section 119.0701, F.S., the BROKER shall (1) keep and maintain public records required by the DISTRICT in order to perform the service; (2) upon request from the DISTRICT'S custodian of public records, provide the DISTRICT with a copy of the requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided by law; (3) ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the duration of the term of this Agreement and following completion of the Agreement if the BROKER does not transfer the records to the DISTRICT; and (4) upon completion of this Agreement, transfer, at no cost to the DISTRICT, all public records in possession of the BROKER or keep and maintain public records required by the DISTRICT to perform the service. If the BROKER transfers all public records to the DISTRICT upon completion of this Agreement, the BROKER shall destroy any duplicate public records that are exempt or

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confidential and exempt from public records requirements. If the BROKER keeps and maintains public records upon completion of this Agreement, the BROKER shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to the DISTRICT, upon request from the DISTRICT'S custodian of public records, in a format that is compatible with the information technology systems of the DISTRICT

6.3. IF THE BROKER HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO THE BROKER'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS CONTRACT, CONTACT THE CUSTODIAN OF PUBLIC RECORDS by telephone at 352-796-7211, ext. 5555, by email at RecordsCustodian@SWFWMD.state.fl.us**, or at the following mailing address:**

Public Records Custodian
Southwest Florida Water Management District
2379 Broad Street
Brooksville, Florida 34604-6899

Any changes to the above contact information will be provided to the BROKER in writing.

6.4. This paragraph, including all subparagraphs, shall survive the expiration or termination of this Agreement.

7. OWNERSHIP OF REPORTS, DOCUMENTS AND OTHER MATERIALS.

The BROKER will provide the DISTRICT with any and all reports, analysis, models, studies, or other documents resulting from the PROJECT at no cost to the DISTRICT.

7.1 All original documents prepared by the BROKER are instruments of service and shall become property of the DISTRICT. The use of data gathered under this Agreement, excluding the data in the public domain, shall not be used in connection with other contracts or for other clients of the BROKER without the written permission of the DISTRICT. The BROKER will provide the DISTRICT with reproducible copies of all reports and other documents. Copies of electronic media used to store data shall be provided to the DISTRICT in a format suitable for hard copy print out. The BROKER shall retain ownership and property interest in its pre-existing intellectual property and pre-existing work products.

7.2 The BROKER shall make any patentable product or result of the Nature of Services Required and all information, design, specifications, data, and findings available to the DISTRICT if requested by the DISTRICT. No material prepared in connection with the PROJECT will be subject to copyright by the BROKER. The DISTRICT shall have the right to publish, distribute, disclose and otherwise use any material prepared by the BROKER pursuant to this Agreement.

7.3 For a period of five (5) years after completion of this Agreement, the BROKER agrees to provide the DISTRICT with copies of any additional materials in its

possession resulting from the performance of this Agreement. However, this provision shall not be considered a waiver of any claim of attorney/client privilege to which the BROKER is entitled. The BROKER shall not publish, copyright, or patent any of the data furnished or developed pursuant to this Agreement without first obtaining the DISTRICT'S written consent.

7.4 The provisions of this Paragraph 7 shall survive the expiration or termination of this Agreement.

8. BROKER'S ACKNOWLEDGMENTS AND REPRESENTATIONS.

The BROKER acknowledges and explicitly represents to the DISTRICT the following:

8.1 The BROKER is duly authorized to conduct business in the State of Florida.

8.2 The BROKER has familiarized itself with the nature and extent of this Agreement, work expected to be performed under this Agreement, and federal, state and local laws, statutes, rules, regulations, ordinances, orders and decisions, that may affect the BROKER'S performance of this Agreement.

8.3 The BROKER has reviewed this Agreement (including its Exhibits) and all available information and data shown or indicated in this Agreement and has given the DISTRICT written notice of all conflicts, errors, ambiguities, or discrepancies that it has discovered in this Agreement or information or data, and the written resolution thereof by the DISTRICT is acceptable to the BROKER.

8.4 The BROKER shall obtain and review all information and data which relates to this Agreement or which the BROKER may reasonably anticipate may affect cost, scheduling, progress, performance or furnishing of any services required under this Agreement, including but not limited to, information and data indicated in this Agreement or related to work under separate agreements, to the extent such work may interface with the BROKER'S work provided pursuant to this Agreement.

9. BUSINESS ASSOCIATE AGREEMENT.

The Broker hereby agrees to comply fully with the HIPAA regulations as a "Business Associate" as set forth in the attached Business Associate Agreement (Exhibit "C"). Additionally, BROKER hereby agrees to ensure that any third party that receives personal health information provided to BROKER by the DISTRICT under this Agreement shall also comply fully with the HIPAA regulations as a "Business Associate" as set forth in the attached Business Associate Agreement.

9.1 To the extent allowed by law, Business Associate agrees to indemnify and hold harmless the DISTRICT from any and all loss, damage or liability suffered by the DISTRICT which is or may be caused by the Business Associate's intentional or negligent failure to comply, in whole or in any part, with this Agreement or any obligation or duty owed under this Agreement, the Health Information Portability and Accountability Act of 1996, as codified at 42 U.S.C.A. § 1320d, the Health Information Technology Act of 2009, as codified at 42 U.S.C.A. § 17901, or any

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rule or regulation promulgated pursuant to either of those, or any other law applicable to the execution of this Agreement.

9.2 The provision shall survive the expiration or termination of this Agreement.

10. STANDARD OF PERFORMANCE.

The BROKER shall perform and complete all services in a timely manner in accordance with the standard of care, skill and diligence customarily provided by an experienced professional rendering the same services, and in accordance with sound principles and practices. The DISTRICT shall decide all questions, difficulties and disputes of any nature whatsoever that may arise under or by reason of this Agreement, the prosecution and fulfillment of the work called for hereunder, or the character, quality, amount, or value thereof. The decision of the DISTRICT upon all such claims, questions, or disputes shall be reasonable and in adherence with sound principles and practices applicable to the professional services.

11. INDEMNIFICATION.

The BROKER agrees to defend, indemnify and hold harmless the DISTRICT and all DISTRICT agents, employees and officers from and against all liabilities, claims, damages, expenses or actions, either at law or in equity, including attorneys' fees and costs and attorneys' fees and costs on appeal, caused or incurred, in whole or in part, as a result of any act or omission by the BROKER, its agents, employees, subcontractors, assigns, heirs or anyone for whose acts or omissions any of these persons or entities may be liable during the BROKER'S performance under this Agreement. This paragraph shall survive the expiration or termination of this Agreement.

12. CONFIDENTIALITY.

During the performance of its obligations or rights under this Agreement, the BROKER may have access to certain information (hereinafter referred to as "Confidential Information") including information exempt under Section 119.071, Florida Statutes, (F.S.), Florida's Public Records Act, which includes, but is not limited to, social security numbers, bank account numbers, and debit, charge, credit card numbers (Section 119.071(5)), and trade secrets as that term is defined at Section 812.081, F.S. (Section 119.071(1)(f)). The BROKER'S access to social security numbers is subject to Section 119.071(5)(a)7., F.S. Exempt information under Section 119.071, F.S. shall be considered Confidential Information regardless of whether such information is marked as confidential. The BROKER shall not disclose, publish or communicate Confidential Information to any third party without the prior written consent of the DISTRICT. However, the BROKER may disclose the Confidential Information to a third party who has a need to know the Confidential Information to accomplish the purpose of the Agreement and is under a written obligation of confidentiality at least as restrictive as this Agreement. The BROKER shall not use the Confidential Information nor circulate it within its own organization except to the extent necessary to accomplish the purpose of this Agreement. Upon demand or if not otherwise demanded, upon the termination of such project or purposes, the Confidential Information and all copies thereof and notes made therefrom shall be immediately returned to the DISTRICT. The BROKER shall comply and warrants that it

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has complied with implementing all applicable data protection and privacy laws and regulations in any relevant jurisdiction. This paragraph shall survive the termination or expiration of this Agreement.

13. INSURANCE REQUIREMENT.

The BROKER must maintain during the entire term of this Agreement, insurance in the following kinds and amounts or limits with a company or companies authorized to do business in the State of Florida and will not commence work under this Agreement until the DISTRICT has received an acceptable certificate of insurance showing evidence of such coverage. Certificates of insurance must reference the DISTRICT Agreement Number and Project Manager.

13.1 Liability insurance on forms no more restrictive than the latest edition of the Commercial General Liability policy (CG 00 01) of the Insurance Services Office without restrictive endorsements, or equivalent, with the following minimum limit and coverage:

Per occurrence	$1,000,000

13.2 Vehicle liability insurance, including owned, non-owned and hired autos with the following minimum limits and coverage:

Bodily Injury Liability per Person	$ 100,000
Bodily Injury Liability per Occurrence	$ 300,000
Property Damage Liability	$ 100,000
or	
Combined Single Limit	$ 500,000

13.3 The DISTRICT and its employees, agents, and officers must be named as additional insureds on the general liability policy to the extent of the DISTRICT'S interests arising from this Agreement.

13.4 The BROKER must carry Workers'' compensation insurance in accordance with Chapter 440, F.S., if applicable. If the BROKER does not carry Workers'' compensation coverage, the BROKER must submit to the DISTRICT both an affidavit stating that the BROKER meets the requirements of an independent contractor as stated in Chapter 440, F.S. and a certificate of exemption from Workers'' compensation coverage.

13.5 Professional liability (errors and omissions) insurance in a minimum amount of One Million Dollars ($1,000,000).

13.6 The BROKER must notify the DISTRICT in writing of the cancellation or material change to any insurance coverage required by this Agreement. Such notification must be provided to the DISTRICT within five (5) business days of the BROKER’S notice of such cancellation or change from its insurance carrier.

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13.7 The BROKER must obtain certificates of insurance from any subcontractor otherwise the BROKER must provide evidence satisfactory to the DISTRICT that coverage is afforded to the subcontractor by the BROKER'S insurance policies.

14. TERMINATION WITHOUT CAUSE.

This Agreement may be terminated by the DISTRICT without cause upon ten (10) days written notice to the BROKER. Termination is effective upon the tenth (10^{th}) day as counted from the date of the written notice. In the event of termination under this paragraph, the BROKER will be entitled to compensation for all services provided to the DISTRICT up to the date of termination on a pro-rated basis and which are within the Nature of Services Required in Exhibit "A," are documented in the Compensation Plan, and are allowed under this Agreement. Within ten (10) days of the DISTRICT'S termination of this Agreement, all charts, studies, analysis and other documents including all electronic copies related to the PROJECT authorized under this Agreement, whether finished or not, must be provided to the DISTRICT. The DISTRICT shall have no obligation to pay the BROKER under this provision until the aforementioned documents are provided to the DISTRICT.

15. DEFAULT.

Either party may terminate this Agreement upon the other party's failure to comply with any term or condition of this Agreement, as long as the terminating party is not in default of any term or condition of this Agreement at the time of termination. To effect termination, the terminating party will provide the defaulting party with a written "Notice of Termination" stating its intent to terminate and describing all terms and conditions with which the defaulting party has failed to comply. If the defaulting party has not remedied its default within thirty (30) days after receiving the Notice of Termination, this Agreement will automatically terminate. In addition, the initiation, either by the BROKER or against the BROKER, of proceedings in bankruptcy, or other proceedings for relief under any law for the relief of debtors, or the BROKER becoming insolvent, admitting in writing its inability to pay its debts as they mature or making an assignment for the benefit of creditors will constitute a default by the BROKER entitling the DISTRICT to terminate this Agreement as set forth above. The parties agree that this Agreement is an executory contract. If, after termination by the DISTRICT, it is determined that the BROKER was not in default, or that the default was excusable, the rights and obligations of the parties shall be the same as if the termination had been issued for the convenience of the DISTRICT. The rights and remedies in this provision are in addition to any other rights and remedies provided by law or this Agreement.

16. RELEASE OF INFORMATION.

The BROKER agrees not to initiate any oral or written media interviews or issue press releases on or about the PROJECT without providing notices or copies to the DISTRICT'S Project Manager and Public Affairs Bureau Chief no later than three (3) business days prior to the interview or press release.

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17. ASSIGNMENT.

Except as otherwise provided in this Agreement, the BROKER may not assign any of its rights or delegate any of its obligations under this Agreement without the prior written consent of the DISTRICT.

18. EMPLOYMENT ELIGIBILITY VERIFICATION. CONSULTANT.

BROKER must utilize the U.S. Department of Homeland Security's Employment Verification (E-Verify) Program to verify the employment eligibility of the BROKER employees performing work directly associated with this Agreement in accordance with the terms and conditions applicable to the E-Verify Program. If BROKER uses subcontractors to furnish services directly associated with this Agreement, performed in the United States, in an amount greater than $3,000, the BROKER must include the requirements of this provision (appropriately modified for identification of the parties) in each subcontract. Information on registration for and use of the E-Verify Program can be obtained via the Internet at the Department of Homeland Security Web site: *http://www.dhs.gov/E-Verify*.

19. LAW COMPLIANCE.

The BROKER will abide by and assist the DISTRICT in satisfying all applicable federal, state and local laws, rules, regulations and guidelines, related to performance under this Agreement. The BROKER will not discriminate against any employee or applicant for employment because of race, color, religion, sex, handicap, disability, marital status or national origin.

20. VENUE AND APPLICABLE LAW.

All claims, counterclaims, disputes and other matters in question between the parties to this Agreement, arising out of or relating to this Agreement or the breach of it will be decided in accordance with the laws of the State of Florida and by a court of competent jurisdiction within the State of Florida, and Venue will lie exclusively in the County of Hillsborough. This provision shall survive the expiration or termination of this Agreement.

21. REMEDIES.

Unless specifically waived by the DISTRICT, the BROKER'S failure to timely comply with any obligation in this Agreement will be deemed a breach of this Agreement and the expenses and costs incurred by the DISTRICT, including attorneys' fees and costs and attorneys' fees and costs on appeal, due to said breach will be borne by the BROKER. Additionally, the DISTRICT will not be limited by the above but may avail itself of any and all remedies under Florida law for any breach of this Agreement. The DISTRICT'S waiver of any of the BROKER'S obligations will not be construed as the DISTRICT'S waiver of any other obligations of the BROKER.

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22. ATTORNEY FEES.

Should either party employ an attorney or attorneys to enforce any of the provisions of this Agreement, or to protect its interest in any matter arising under this Agreement, or to recover damages for the breach of this Agreement, the party prevailing is entitled to receive from the other party all reasonable costs, charges and expenses, including attorneys' fees, expert witness fees, fees and costs on appeal, and the cost of paraprofessionals working under the supervision of an attorney, expended or incurred in connection therewith, whether resolved by out-of-court settlement, arbitration, pre-trial settlement, trial or appellate proceedings, to the extent permitted under Section 768.28, F.S. This provision does not constitute a waiver of the DISTRICT'S sovereign immunity or extend the DISTRICT'S liability beyond the limits established in Section 768.28, F.S. This provision shall survive the expiration or termination of this Agreement.

23. SUBCONTRACTORS.

Nothing in this Agreement will be construed to create, or be implied to create, any relationship between the DISTRICT and any subcontractor of the BROKER.

24. DISADVANTAGED BUSINESS ENTERPRISES.

The DISTRICT expects the BROKER to make good faith efforts to ensure that disadvantaged business enterprises, which are qualified under either federal or state law, have the maximum practicable opportunity to participate in contracting opportunities under this Agreement. Invoice documentation submitted to the DISTRICT under this Agreement must include information relating to the amount of expenditures made to disadvantaged businesses by the BROKER in relation to this Agreement, to the extent the BROKER maintains such information.

25. THIRD PARTY BENEFICIARIES.

Nothing in this Agreement will be construed to benefit any person or entity not a party to this Agreement.

26. CONFLICTING EMPLOYMENT.

The BROKER certifies that at the time of execution of this Agreement, the BROKER is not involved in any matters which adversely affect any interest or position of the DISTRICT, and that the BROKER has no relationship with any third party, relating to any matters which adversely affect any interest or position of the DISTRICT. The BROKER further agrees that it will not accept during the term of this Agreement any retainer or employment from a third party whose interests appear to be conflicting or inconsistent with those of the DISTRICT.

27. PUBLIC ENTITY CRIMES.

Pursuant to Subsections 287.133(2) and (3), F.S., a person or affiliate who has been placed on the convicted vendor list following a conviction for a public entity crime may not submit a bid, proposal, or reply on a contract to provide any goods or services to a public

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entity; may not submit a bid, proposal, or reply on a contract with a public entity for the construction or repair of a public building or public work; may not submit bids, proposals, or replies on leases of real property to a public entity; may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity; and may not transact business with any public entity in excess of the threshold amount provided in Section 287.017, F.S., for Category Two, for a period of 36 months following the date of being placed on the convicted vendor list. By signing this Agreement, the BROKER warrants that it is not currently on a suspended vendor list and that it has not been placed on a convicted vendor list in the past 36 months. The BROKER further agrees to notify the DISTRICT if placement on either of these lists occurs.

28. SCRUTINIZED COMPANIES.

Pursuant to Section 287.135, F.S., a company that, at the time of submitting a bid or proposal for a new contract or renewal of an existing contract, is on the Scrutinized Companies that Boycott Israel List, or is engaged in a boycott of Israel, is ineligible to, and may not bid on, submit a proposal for, or enter into or renew a contract with an agency or local governmental entity for goods or services in any amount. If the goods or services are in the amount of $1 million dollars or more, the company must also not be on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, or be engaged in business operations in Cuba or Syria. By signing this Agreement, the COOPERATOR certifies that it is not on any of the lists or engaged in any of the prohibited activities identified above, as applicable based upon the amount of this Agreement. The COOPERATOR agrees to notify the DISTRICT if it is placed on any of the applicable lists or engages in any of the prohibited activities during the term of this Agreement. The DISTRICT may immediately terminate this Agreement at its option if the COOPERATOR is found to have submitted a false certification, is placed on any of the applicable lists or engages in any prohibited activities.

29. ENTIRE AGREEMENT.

This Agreement and the attached exhibits listed below constitute the entire agreement between the parties and, unless otherwise provided herein, may be amended only in writing, signed by all parties to this Agreement.

30. DOCUMENTS.

The following documents are attached or incorporated herein by reference and are made a part of this Agreement. In the event of a conflict of contract terminology, priority will first be given to the language in the body of this Agreement, then to Exhibit "A," and then to Exhibit "B," then to Exhibit “C,” then to ITN 1911, and then to the Broker’s Response to ITN 1911.

Exhibit "A" - Nature of Services Required
Exhibit "B" - Compensation Plan
Exhibit “C” - Business Associate Agreement
ITN 1911 Insurance Broker Services for Health, Property and Casualty and Workers’ Compensation Broker's Response to ITN 1911.

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IN WITNESS WHEREOF, the parties hereto, or their lawful representatives, have executed this Agreement on the day and year set forth next to their signatures below.

SOUTHWEST FLORIDA WATER MANAGEMENT DISTRICT

By: Amanda Rice 12/30/2019

Amanda Rice, P.E. Date
Assistant Executive Director

RISK MANAGEMENT ASSOCIATES, INC. DBA
PUBLIC RISK INSURANCE ADVISORS

By: 12/30/2019

Date

Name: Matt Montgomery

Title: EVP

Authorized Signatory

AGREEMENT BETWEEN THE
SOUTHWEST FLORIDA WATER MANAGEMENT DISTRICT
AND
RISK MANAGEMENT ASSOCIATES, INC. DBA
PUBLIC RISK INSURANCE ADVISORS
FOR
INSURANCE BROKER SERVICES FOR HEALTH, PROPERTY AND CASUALTY,
AND WORKERS' COMPENSATION

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Exhibit "A"
NATURE OF SERVICES REQUIRED
A. HEALTH INSURANCE BROKER

3.1 **SCOPE OF WORK.**

The successful Respondent shall provide the following services to the District, as needed.

3.1.1 Assist in determining specifications for future medical, dental and other insured employee benefits coverage including but not limited to life insurance, accidental death and disability, long term disability, vision, supplemental, discounted programs, health and wellness, etc.

3.1.2 Assist with development of procurement documents in accordance with District specifications and procurement procedures.

3.1.3 Assist with identification of appropriate markets for desired medical, dental and other insured employee benefits.

3.1.4 Analyze and evaluate medical, dental and other insured employee benefits products submitted for consideration by providers and provide options and make recommendations.

3.1.5 Assist with contract negotiation.

3.1.6 Audit resulting contracts for accuracy of coverage and contract compliance.

3.1.7 Regularly assess current market trends involving employee benefits.

3.1.8 Assist with annual medical, dental and other insured employee benefits procurements and renewals, including negotiation of changes in contracts in accordance with the terms of the provider’s solicitation.

3.1.9 Provide thorough analysis and recommendations for medical, dental and other insured employee benefits for quality of benefits provided, cost effectiveness, competitiveness and plan administration on an annual basis.

3.1.10 Maintain active and ongoing communications with the providers to ensure smooth operation and delivery of benefits, as well as facilitating prompt review and resolution of plan and claims administration issues.

3.1.11 Provide a dedicated customer service team to answer questions and resolve issues that arise during the year regarding employee benefits, contract administration, and service provisions.

3.1.12 Provide plan design and financial management performance updates for all brokered benefit plans, at least quarterly, via detailed analysis, review, and

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evaluation of costs, claims, and trends.

3.1.13 Provide "Annual Stewardship Report," which will include complete accounting of fees and commissions earned on the account, observations on relevant changes in the insurance market, view on loss exposures facing the District and loss control activities.

3.1.14 Serve as a resource to District staff on Federal and State benefits laws, including but not limited to: COBRA, HIPAA, FMLA, the Affordable Health Care Act, ADA, etc.

3.1.15 Promptly inform District staff of changing legislation and legal decisions affecting employee benefits and consult with District's Office of General Counsel on methods of compliance.

3.1.16 Assist with legally required reporting and compliance with statutes, rules, regulations and codes, including required employee communications and notices.

3.1.17 Make regularly scheduled visits to District service offices to provide information and guidance, respond to questions, solve problems, and assist with benefit administration.

3.1.18 Assist in the development of the annual open enrollment benefits package and participate in open enrollment meetings for all employees.

3.1.19 Assist with development of year-round informational and wellness materials, communications, employee meetings, health events (such as health fairs and screenings), etc. to maximize employees' knowledge and understanding of how to be the best consumer of the employee benefits plan.

3.1.20 Provide on-site employee enrollment meetings for new hires.

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3.2 **PERFORMANCE SCHEDULE.**

Respondents must be able to meet the District's timeline.

January	Execution of Brokerage Agreement.
February (when and if needed)	Finalize and issue an Invitation to Negotiate (ITN) for Employee Benefits Insurance Plans.
April	Receive and review responses from providers
July	If ITN for new coverage is not needed, begin renewal process for existing insurance plans to renew Jan. 1 the following year.
August	Get new providers in place and begin transition activities and implementation of new plan(s).
August and September	Coordinate with selected Respondent, provider(s) and the District's Information Technology Bureau (ITB) to set up structure of new plan(s) in system and perform operational and data transfer testing, troubleshooting, and issue resolution; Begin preparing communication to employees regarding upcoming open enrollment, with assistance of Broker and provider(s).
October	Communicate details of new plan(s) to employees and retirees through Internal Communications, *Currents*, employee open enrollment meetings, with assistance of the District and provider(s).
November and December	Assist with testing files between Human Resource Information System (HRIS) and provider sites and set up for Jan. 1 launch.
Late November – early December	Communication of plan enrollment verification details and legally required information, issuance of new insurance cards, etc., from medical and dental provider(s) to employees, retirees and dependents.
January 1	New health insurance plan year begins.

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Exhibit "A" Cont.
NATURE OF SERVICES REQUIRED
B. PROPERTY AND CASUALTY BROKER

3.1 **SCOPE OF WORK.**

The selected Respondent shall provide the following services to the District, as needed.

3.1.1 The selected Respondent shall work closely with the District's Risk Management staff to routinely evaluate risks and make recommendations for the appropriate mitigation of those risks in a cost-beneficial way, including:

3.1.1.1 Analyze the District's exposure to loss, the adequacy of coverage and developing options on coverage whether or not currently purchased by the District.
3.1.1.2 Perform catastrophe or other modeling to determine levels of exposure to risks.
3.1.1.3 Assist the District in evaluating the appropriate levels for risk mitigation.
3.1.1.4 Advise the District on the various alternatives to handling risks through various forms of insurance, self-insurance, and deductible levels.
3.1.1.5 Advise the District on pertinent insurance matters and attend risk management meetings with the District as desired during the year.
3.1.1.6 Assist in the development of risk management policies and procedures for the District as requested.
3.1.1.7 Make recommendations for enhancing the risk and insurance management program, including providing input regarding coverage issues outside the current program and guidance regarding self-insurance.
3.1.1.8 Bind insurance coverage to the District beyond insurance expiration dates while renewal policies are being put into place.
3.1.1.9 Provide research assistance and consultation on risk management issues.
3.1.1.10 Promptly and accurately process insurance policy endorsements and other change requests as needed.
3.1.1.11 At a minimum conduct an annual review with the Human Resources Office Chief of the premium/claims history of the District for the policies purchased.
3.1.1.12 Provide training to District Risk Management staff.

3.2.2 Assist with all tasks related to the annual renewal process for all property and casualty insurance coverages available including:

3.2.2.1 Assist with a marketing plan to include competitively soliciting at least three (3) quotes from providers or administering a formal solicitation in accordance with District specifications and procurement procedures.
3.2.2.2 Assist the District in developing optional coverage and limit structures for property and casualty lines of coverage.

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3.2.2.3 Review the District's property data and advise of any data elements needed for underwriting evaluations, including sufficiency of Construction, Occupancy, Protection and Exposure (COPE) data.

3.2.2.4 Advise the District of availability of coverage and alternative risk transfer mechanisms for casualty lines of coverage; and notify the District of any data elements needed for underwriting evaluations, after a review of claim data.

3.2.2.5 Advise the District of current market pricing and availability of insurance coverage at least four months prior to the expiration of insurance coverage then in effect.

3.2.2.6 Annually, analyze the insurance market conditions, taking into account other insurance programs competing with the District's program for insurance coverage, seasonable perils, reinsurance treaty dates and any other factors that may affect insurance availability and pricing, and advise the District of the best time to procure insurance coverage.

3.2.2.7 Annually, review the District's policy for possible changes/enhancements and to ensure that the policy's language, coverage and exclusions are consistent with the District's certificate of coverage.

3.2.2.8 Serve as subject matter experts to the District on upcoming insurance procurements; and formulate a price and coverage negotiating strategy to support the District's choice of the recommendations presented on the insurance procurement.

3.2.2.9 Assist with the coordination of the renewal process and provide to the District a renewal notification detailing anticipated coverage, limit, retention and pricing changes at least three months prior to policy inception and each year thereafter during the contract period.

3.2.2.10 Assist with the drafting of the insurance specifications, compile underwriting information and other pertinent information with the input of the District.

3.2.2.11 Prepare formal market submissions for distribution to underwriters, submit the market submission to the District for distribution approval, and distribute the approved market submission to underwriters on behalf of the District in a timely manner.

3.2.2.12 Negotiate renewal terms, conditions and pricing on behalf of and in conjunction with the District; place all insurance coverage approved by the District.

3.2.2.13 If applicable, fully disclose the amount and percentage of commission to be paid by the selected Respondent to any excess insurance broker, intermediary or wholesaler used in the placement process, and state their relationship, if any, to the selected Respondent.

3.2.2.14 Report placement results to the District and bind coverage as directed by the District; and obtain all necessary binding documents in a timely and effective manner.

3.2.2.15 Check binders, policies and endorsements to ensure they are issued according to specifications before delivery to the District.

3.2.2.16 Forward binders to the District before or on the policy's effective date.

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3.2.2.17 Issue endorsements and insurance certificates as may be needed based on the insurance program structure.

3.2.2.18 Provide an annual summary of program terms and costs to the District that includes:

- market review that lists all carriers that were approached;
- their AM Best rating;
- insurer status (admitted or non-admitted);
- marketing status (quoted, declined, accepted, bound);
- quoted amounts/comments;
- synopsis of current market conditions;
- renewal results with comparisons to the expiring policies;
- renewal program coverage quilt/mosaic;
- a premium summary listing all carriers;
- amounts authorized, price, and sorted by coverage layer and detailing any assessments or surcharges;
- summary of the District's exposures;
- catastrophe modeling summary and results;
- any disclosures customarily provided by the selected Respondent to the District at the time of renewal; and
- provide a disclosure in the annual summary that no income other than the compensation allowed by the Agreement has been received by the Respondent for services provided during the period covered by the annual summary.

3.2.2.19 Provide policies to the District as soon as issued or received by the providers, or upon instructions by the District:

- collect all policies;
- consolidate policies into a binder and submit the binder to the District once all policies have been received;
- ensure the timely billing of all documents and premiums;
- In the event a Notice of Cancellation has been issued due to nonpayment of premium, act on the District's behalf to resolve the issue with the Insurer and maintain insurance coverage;
- assist the District with exposure issues or insurance contract provisions as needed on an ongoing basis;
- evaluate the commitment and financial stability of the provider on an ongoing basis;
- notify the District of any changes in the provider's AM Best ratings;
- notify the District of any additional coverage that may become available in the marketplace that could be advantageous to the District and assist in the procurement of such coverage as instructed by the District; as needed but at least semi-annually;
- present market updates to keep the District informed of any conditions or developments that may affect existing policies or future insurance placements;

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- act as a liaison with the provider that requests property inspections; and
- assist the District in responding to and implementing any recommendations made as a result of property inspections.

3.2.3 Claims Administration.

3.2.3.1 Prepare and issue all certificates of insurance within 2 days of request or sooner when such request is specified as an emergency.

3.2.3.2 Coordinate notice of claims and/or losses to underwriters and act as a facilitator during the claim process.

3.2.3.3 Work closely with providers and act as a liaison between the District and providers that are contracted by the District to assist in areas that include, but are not limited to, delivering provider policies to the District, handling invoice issues, and other issues that may arise.

3.2.3.4 Answer questions and resolve coverage issues related to policy coverage, work with the District's management, legal counsel and/or auditors to provide needed information and expertise.

3.2.3.5 Respond in a timely manner to audit inquiries and attend meetings related to audits involving risk management.

3.2.3.6 Advise the District of trends and/or changes in the insurance industry.

3.2.3.7 Make presentations to the District's Governing Board, Board committees or management.

3.2.3.8 Coordinate reporting of claims with third party administrators.

3.2.3.9 Review the District contracts to determine if additional risk exposures are present. Assist the District in re-evaluating insurance requirements for various contracts (design, construction and service). Review certain leases, agreements for insurance requirements, assumption of liability and other risk management issues.

3.2.3.10 Prepare and submit special reports, loss analyses, SOC_1 Type-2 report, etc.

3.2.3.11 Obtain proper return premiums, if required, necessitated by mid-term cancellations and validate any additional premiums for accuracy.

3.2.3.12 Coordinate the selection of a mutually agreed upon adjusting firm that has experience in adjusting catastrophic losses.

3.2.3.13 Forward notification provided by the District to the insurers of any large losses reported above thresholds to be established by the provider for individual and aggregate losses on a per occurrence basis.

3.2.3.14 In the event that losses from an occurrence exceed the District's self-insured retention, act as an advocate for the District and as an intermediary between the District, providers and the mutually agreed upon adjusting firm to facilitate communications, data exchange and prompt resolution of claims.

3.2.3.15 Provide general assistance in the administration of the District's program.

3.2.3.16 Provide additional services as may be assigned in accordance with the agreement and this Part III Nature of Services Required, Subpart B. No work will be complete under additional service without prior written authorization from the District to perform the work.

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3.2.4 Contract Manager.

3.2.4.1 The selected Respondent's Lead Account Manager or Contract Manager must have one or more of the following certificates or accreditations: Chartered Property Casualty Underwriter (CPCU); Accredited Advisor in Insurance (AAI); Certified Insurance Counselor (CIC); Associate in Risk Management (ARM). The selected Respondent must employ individuals who are appropriately licensed and registered with the State of Florida. Only licensed and registered employees of the selected Respondent shall provide services under the Agreement.

3.2.4.2 At a minimum, the selected Respondent shall assign a Contract Manager to work directly with the District's designated Contract Manager and other staff in providing the services specified in the Agreement. The District's Contract Manager shall coordinate all activities between the District and the selected Respondent.

3.3 PERFORMANCE SCHEDULE.

Respondents must be able to meet the District's timeline.

October	Execution/Renewal of Brokerage Agreement.
June (when and if needed)	Finalize and issue an Invitation to Negotiate (ITN) for Property and Casualty Insurance Plans.
July-August	Receive and review responses from Property and Casualty Insurance Plans. Advise the District of current market pricing and availability of insurance coverage.
August 30th	Provide to the District a renewal notification detailing anticipated coverage, limit, retention and pricing changes. Get new providers in place and begin transition activities and implementation of new plan(s).
September	Communicate details of new plan(s) to stakeholders with assistance of the District and provider(s).
September	Coordination and execution of contracts or renewals with providers for Property and Casualty services.
October 1	New property and casualty insurance plan year begins.

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Exhibit "A" Cont.
NATURE OF SERVICES REQUIRED
C. WORKERS' COMPENSATION BROKER

3.1 **SCOPE OF WORK.** The selected Respondent shall provide the following services to the District, as needed:

3.1.1 Audit stop loss contracts for accuracy of coverage, terms and conditions.

3.1.2 Assist with annual workers' compensation renewals, including negotiation of changes in stop loss contracts.

3.1.3 Assist with development of procurement documents in accordance with District specifications and procurement procedures.

3.1.4 Assist with identification of appropriate markets for workers' compensation.

3.1.5 Analyze and evaluate workers' compensation products submitted for consideration by providers and provide options and make recommendations.

3.1.6 Review the quality of workers' compensation provided, cost effectiveness, competitiveness and administration on an annual basis.

3.1.7 Monitor ongoing stop loss contracts, including third party administrators, to ensure contract compliance.

3.1.8 Analyze claim history and utilization at least quarterly.

3.1.9 Provide information on workers' compensation issues, trends and proposed or new legislation.

3.1.10 Meet with the District staff as needed.

3.1.11 Provide a key contact person to answer questions and resolve issues that arise regarding employee workers' compensation, contract administration, and service provisions.

3.1.12 Perform other related consultation services as needed or requested.

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3.2 **PERFORMANCE SCHEDULE.**

Respondents must be able to meet the District's timeline.

October	Execution of Brokerage Agreement.
June (when and if needed)	Finalize and issue an Invitation to Negotiate (ITN) for Workers' Compensation Insurance Plans.
July-August	Receive and review responses from Workers' Compensation Insurance Plans.
August 30th	Get new providers in place and begin transition activities and implementation of new plan(s).
September	Communicate details of new plan(s) to stakeholders with assistance of the District and provider(s).
September	Coordination and execution of contracts or renewals with providers for workers' compensation services.
October 1	New workers' compensation insurance plan year begins.

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Exhibit "B"
COMPENSATION PLAN

FEE SCHEDULE

HEALTH INSURANCE BROKER, PROPERTY AND CAUSULATY BROKER & WORKERS' COMPENSATION

COVERAGE	COMPENSATION
Brokerage Services for all Lines (Health, Property & Casualty, and Workers' Compensation)	$162,500 Annual Fee

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Exhibit "C"
BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is entered into by and between the Southwest Florida Water Management District (District) and Risk Management Associates, Inc. dba Public Risk Insurance Advisors (Business Associate) (each a "Party" and collectively the "Parties"), and is made a part of any agreement or service agreements between the parties ("Service Agreement") pursuant to which the Business Associate provides a service or services to the District that involves the use and/or disclosure of the District's Protected Health Information ("PHI").

NOW, THEREFORE, for good and valuable consideration, the sufficiency of which we hereby acknowledge, the Parties agree as follows:

I. DEFINITIONS:

A. Terms used but not otherwise defined in this Agreement shall have the same meaning as the meaning ascribed to those terms in the Health Information Portability and Accountability Act of 1996, as codified at 42 U.S.C. § 1320d ("HIPAA"), the Health Information Technology Act of 2009, as codified at 42 U.S.C.A. prec. § 17901 ("HITECH Act"), and any current and future regulations promulgated under HIPAA or the HITECH Act (HIPAA, HITECH Act and any current and future regulations promulgated under either are referred to as the "Regulations").

B. Protected Health Information or PHI. "Protected Health Information" or "PHI" shall have the same meaning as the term "Protected Health Information" in 45 CFR 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity, including, but not limited to electronic PHI.

II. OBLIGATIONS OF BUSINESS ASSOCIATE

In order for the Business Associate to achieve and maintain compliance with the requirements of HIPAA, the Business Associate agrees:

A. To only use and disclose PHI as permitted by this Agreement or as required by law. The Business Associate may:

1. Use and disclose PHI to perform its obligations as set forth in the Service Agreement;

2. Use PHI for the proper management and administration of the Business Associate or to carry out its legal responsibilities;

3. Disclose PHI for the proper management and administration of Business Associate or to carry out its legal responsibilities, if such disclosure is required by law or if the Business Associate obtains reasonable assurances from the recipient that the recipient will keep the PHI confidential, use or further disclose the PHI only as required by law or for the purpose for which it was disclosed to the recipient, and notify the

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Business Associate of any instances of which it is aware in which the confidentiality of the PHI has been breached;

4. Use PHI to provide data aggregation services relating to the health care operations of the District;

5. Use or disclose PHI to report violations of the law to law enforcement; and

6. Use PHI to create de-identified information consistent with the standards set forth at 45 CFR §164.514. The Business Associate will not sell PHI or use or disclose PHI for purposes of marketing, as defined and proscribed in the Regulations.

B. To limit its uses and disclosures of, and requests for, PHI (a) when practical, to the information making up a Limited Data Set; and (b) in all other cases subject to the requirements of 45 CFR 164.502(b), to the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request;

C. To use appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of the PHI in compliance with the Regulations;

D. To require all of its subcontractors and agents that receive, use or have access to PHI to agree, in writing, to adhere to the same restrictions and conditions on the use or disclosure of PHI that apply to the Business Associate pursuant to this Agreement;

E. Upon reasonable notice and prior written request, to make available during normal business hours at the Business Associate's offices all records, books, agreements, internal practices, policies and procedures relating to the use or disclosure of PHI to the Secretary, in a time and manner designated by the Secretary, for purposes of determining the Business Associates compliance with the Regulations, subject to attorney-client and other applicable legal privileges;

F. To provide documentation regarding any disclosures by the Business Associate that would have to be included in an accounting of disclosures to an Individual under 45 CFR 164.528 (including without limitation a disclosure permitted under 45 CFR 164.512) and the HITECH Act, within a reasonable amount of time of receipt of a request from the District;

G. If, and to the extent that the Business Associate possesses an applicable Designated Record Set, within a reasonable amount of time of receipt of a request from the District for the amendment of an individual's PHI contained in the Designated Record Set, the Business Associate shall provide such information to the District for amendment and shall also incorporate any such amendments in the PHI maintained by the Business Associate as required by 45 C.F.R. 164.526.

H. Subject to Section Ill.C.2. of this Agreement, return to the District or destroy, within thirty (30) days of the termination of this Agreement, any and all PHI in its possession and retain no copies (which for purposes of this Agreement shall include without limitation destroying all backup tapes and permanently deleting all electronic PHI).

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I. To mitigate, to the extent practicable, any harmful effects from any use or disclosure of PHI by the Business Associate not permitted by this Agreement.

J. The Business Associate agrees to notify the District of any use or disclosure of PHI by the Business Associate not permitted by this Agreement, any Security Incident involving electronic PHI, and any Breach of Unsecured Protected Health Information within five (5) business days.

1. The Business Associate shall provide the following information to the District within ten (10) business days of discovery of a breach except when despite all reasonable efforts by the Business Associate to obtain the information required, circumstances beyond the control of the Business Associate necessitate additional time. Under such circumstances the Business Associate shall provide to the District the following information as soon as possible and without unreasonable delay, but in no event later than thirty (30) calendar days from the date of discovery of a breach:

    a. the date of the breach;

    b. the date of the discovery of the breach;

    c. a description of the types of unsecured PHI that were involved;

    d. identification of each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed; and

    e. any other details necessary to complete an assessment of the risk of harm to the individual.

2. The Business Associate will be responsible to provide notification to individuals whose unsecured PHI has been disclosed,

3. The Business Associate agrees to investigate the breach, mitigate losses, and protect against any future breaches, and to provide a description of these procedures and the specific findings of the investigation to the District in the time and manner reasonably requested by the District.

Ill. TERM AND TERMINATION

A. Term. This Agreement shall become effective on the date of execution of a Service Agreement, and shall terminate upon the termination or expiration of all Service Agreement(s).

B. Termination for Cause. Either Party may immediately terminate this Agreement and the Service Agreement(s) if such Party makes the determination that the other Party has breached a material term of this Agreement. Alternatively, the terminating Party may choose to provide the other Party with thirty (30) days written notice of the existence of an alleged material breach and an opportunity to cure the breach.

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C. Effect of Termination.

1. Upon termination or expiration of this Agreement, the Business Associate agrees to return to the District or destroy all PHI in the possession of the Business Associate and/or in the possession of any subcontractor or agent of the Business Associate (including without limitation destroying all backup tapes and permanently deleting all electronic PHI) and to retain no copies of the PHI.

2. In the event that returning or destroying the PHI is infeasible, the Business Associate shall provide to the District a written statement that it is infeasible to return or destroy the PHI and describe the conditions that make return or destruction of the PHI infeasible. Upon mutual agreement by the Parties that return or destruction of the PHI is infeasible; the Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as the Business Associate maintains the PHI.

IV. INDEMNIFICATION

The Business Associate agrees to indemnify, defend and hold harmless the District and its respective employees, directors, officers, subcontractors, agents or other members of its workforce (each of the foregoing hereinafter referred to as "Indemnified Party") against all actual and direct losses suffered by the Indemnified Party and all liability to third parties arising from or in connection with any breach of this Agreement or from any acts or omissions related to this Agreement by the Business Associate or its employees, directors, officers, subcontractors, agents or other members of its workforce. Accordingly, on demand, the Business Associate shall reimburse any Indemnified Party for any and all actual and direct losses, liabilities, lost profits, fines, penalties, costs or expenses (including reasonable attorneys' fees) which may for any reason be imposed upon any Indemnified Party by reason of any suit, claim, action, proceeding or demand by any third party which results from the Business Associate's acts or omissions hereunder. The Business Associates' obligation to indemnify any Indemnified Party shall survive the expiration or termination of this Agreement.

V. MISCELLANEOUS

A. Amendments. This Agreement may not be modified, nor shall any provision hereof be waived or amended, except in a writing duly signed by authorized representatives of the Parties. The parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary to achieve and maintain compliance with the requirements of the Regulations.

B. Survival. The obligations of the Business Associate set forth in Sections Ill. C. and IV. shall survive termination of this Agreement.

C. Interpretation. Any ambiguity in this Agreement shall be resolved to permit the Business Associate to comply with HIPAA.

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Southwest Florida Water Management District

Invitation to Negotiate (ITN) 1911

Insurance Broker Services for Health, Property and Casualty, and Workers' Compensation

Response Prepared By:

Risk Management Associates, Inc. dba
Public Risk Insurance Advisors
A wholly owned subsidiary of Brown & Brown, Inc.

Paul Dawson, ARM-P – Senior Vice President
Danielle Boyle, GBA, GBDS – Vice President
220 S. Ridgewood Avenue, Suite 210
Daytona Beach, FL 32114
(386) 239-4045

Submitted: December 4, 2019 at 2:00 PM

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BB PRIA
PUBLIC RISK INSURANCE ADVISORS

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Southwest Florida Water Management District

Invitation to Negotiate #1911

Insurance Broker Services for Health, Property & Casualty and Workers' Compensation

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Section 1

Invitation to Negotiate Form

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SOUTHWEST FLORIDA WATER MANAGEMENT DISTRICT
INVITATION TO NEGOTIATE (ITN)
COVER SHEET

SUBMIT RESPONSES TO: PROCUREMENT SECTION (MAIL CODE: BKV-4-PRO)
SOUTHWEST FLORIDA WATER MANAGEMENT DISTRICT
2379 BROAD STREET - BUILDING #4
BROOKSVILLE, FLORIDA 34604-6899

Direct Inquiries to: Brian C. Bickhardt, Senior Procurement Specialist
Phone: 352-796-7211, Ext. 4135; FAX: 352-754-3497; E-mail: Brian.Bickhardt@watermatters.org

DATE POSTED: November 8, 2019	**DUE DATE / RESPONSES OPENING DATE:** December 4, 2019 at 2:00 p.m. Eastern Time (ET)

PRE-RESPONSE CONFERENCE: NONE

TITLE: ITN 1911 - INSURANCE BROKER SERVICES FOR HEALTH, PROPERTY AND CASUALTY, AND WORKERS' COMPENSATION

SPECIFICATIONS: The Southwest Florida Water Management District (District) seeks the services of a Florida Licensed Insurance Broker(s) for (A) Health, (B) Property and Casualty and (C) Workers' Compensation to assist the District with the development of a strategic plan for the design, negotiation, implementation, analysis, monitoring, measurement and administration of Employee Benefits Insurance Plans, Property and Casualty Insurance and Workers' Compensation Insurance.

Respondent Name: Risk Management Associates, Inc. dba Public Risk Insurance Advisors		Reason for No-Bid
Mailing Address: 220 S. Ridgewood Avenue, Suite 210		
City-State-Zip: Daytona Beach, FL 32114		
Telephone Number (386) 239-4045	FAX Number (386) 239- 4049	Toll-Free Number ( ) - (800) 877-2769

Email address for correspondence: pdawson@bbpria.com

Authorized Signature: Date: 12/3/2019

Full Name (please print or type): Matthew Montgomery

Title (please print or type): Executive Vice President

I, the above signed, as Respondent hereby declare that I have carefully read this Invitation to Negotiate and its provisions, terms, and conditions covering the products and services as called for, and fully understand the requirements and conditions. I certify that this response is made without prior understanding, agreement, or connection with any corporation, firm, entity, or person submitting a response for the same products and services (unless otherwise specifically noted) and is in all respects fair and without collusion or fraud. By signing above, I agree to be bound by all the terms and conditions of this Invitation to Negotiate and certify that I am authorized to sign this response for the Respondent.

IT IS THE RESPONDENT'S RESPONSIBILITY TO ASSURE THAT ITS SEALED RESPONSE IS DELIVERED AT THE PROPER TIME TO THE SPECIFIED LOCATION. RESPONSES RECEIVED AFTER THE DATE AND TIME SPECIFIED WILL NOT BE ACCEPTED.

FORM 15.00 - 015 (05/07)

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SOUTHWEST FLORIDA WATER MANAGEMENT DISTRICT
2379 BROAD STREET
BROOKSVILLE, FLORIDA 34604-6899
TELEPHONE: 352-796-7211 FAX: 352-754-3497

November 22, 2019

ITN 1911
Insurance Broker Services

ADDENDUM #1
(Acknowledgment is Required)

The Consultant must acknowledge the receipt of this Addendum by signing below and including a signed copy of this Addendum with its Bid Response.

Please note that underlined information (*example*) is added wording and stricken information (~~*example*~~) is deleted wording.

Please note the following Section 2.2.2 of the above referenced solicitation has been deleted in its entirety:

~~2.2.2 Respondent must have a rating of at least "A-" by a recognized financial rating service (i.e., A.M. Best).~~

Brian Bickhardt
Senior Procurement Specialist III

AD
cc: Kelley Rexroad

ACKNOWLEDGEMENT OF ADDENDUM #1

BY: _____ 12/3/2019
DATE

Matthew Montgomery, Executive Vice President
(TYPE/PRINT NAME AND TITLE)

Risk Management Associates, Inc. dba Public Risk Insurance Advisors
COMPANY NAME

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Section 2

Letter of Transmittal

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Section 2: Letter of Transmittal

This letter, not to exceed two (2) pages, shall briefly state Respondent's understanding of the work to be performed and make a positive commitment to perform the work in a timely fashion to effectuate the provision of services as outlined in this ITN. The letter must include the names of individuals authorized to make representations for the organization regarding this ITN, their titles, addresses, telephone numbers and email addresses. This letter must be signed by an official authorized to negotiate for Respondent.

September 3, 2019

Attn.: Brian Bickhardt, Senior Procurement Specialist
Southwest Florida Water Management District

Re: ITN 1911 Insurance Broker Services

Mr. Bickhardt,

On behalf of Public Risk Insurance Advisors (PRIA), I am pleased to submit our response to ITN 1911 Insurance Broker Services for Health, Property & Casualty and Workers' Compensation. We trust that you will find the response contained herein to be concise in demonstrating our understanding of the District's solicitation for a qualified professional insurance firm.

Throughout this response, our approach revolves around three main objectives:

1. **Establish a Strategic Plan to Enhance the District's Insurance & Benefits Programs**
2. **Lower the District's Total Cost of Risk**
3. **Provide Concierge-Level Service to District Staff and its Employees**

PRIA is uniquely qualified to provide the services outlined in this ITN. Our firm has served the risk management and employee benefits needs of Florida's public entities for more than 27 years. Our experience includes managing self-funded health insurance programS for numerous Florida public entity clients including many with 500 lives or more. Our property, casualty and workers' compensation experience is second to none with over 250 current Florida public entity clients.

For each of these past 27 years, we have grown our book of business because we have consistently improved our services and bolstered our reputation. It is our intent to demonstrate that service commitment as well as our firm's willingness and ability to provide the District's requested services as outlined in this ITN response.

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Most importantly, we ask you to take special note of the references included in this response. Our written response to the ITN does not speak as loud as those for whom we have delivered exceptional year-over-year results. We challenge you to call those references, ask probing questions, and determine for yourself the real-world impact of our expertise, proactive service commitment, and dedication to the continuous improvement of our client's employee benefits and risk management programs.

The person authorized to make representations for PRIA is Mr. Matthew Montgomery. Contact information for Mr. Montgomery is as follows:

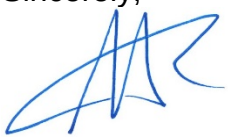
Matthew Montgomery, Executive Vice President, PRIA
220 S. Ridgewood Ave
Daytona Beach, FL 32114
Email: mmontgomery@bbpria.com
Voice: 386-239-7245
Fax: 386-239-4049

Enclosed are all required documents and information. Every effort was made to concisely provide all requested information, all required completed forms, and succinctly illustrate our understanding of the required scope of services as well as other services provided by or recommended by PRIA.

We are available at the request of the District to participate in any oral interviews. Please feel free to contact me should you need further clarification of our proposal.

Please consider this signed document as evidence that this proposal is in all respects fair and in good faith without collusion or fraud. There are no conflicts of interest arising out of any other clients, contracts, or interests associated with this project. The signer has the authority to bind the principal proponent.

Sincerely,



Matthew Montgomery
Executive Vice President

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Section 3

Organizational Profile

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Section 3: Organizational Profile

4.2 ORGANIZATIONAL PROFILE

4.2.1 An overview of the organization, including at a minimum: location(s), size, brief historical background, years in business, business structure of the firm (i.e. corporation, partnership, LLC), range of activities and services provided. (Maximum of three (3) pages)

Public Risk Insurance Advisors (PRIA) is a full-service insurance brokerage and consulting firm that exclusively serves the insurance needs of Florida's public entities and has done so for more than 27 years. We currently represent more than 250 cities, counties, special districts, and schools/universities in the State of Florida as the lead agent for Property & Casualty insurance and Employee Benefits. Because we work exclusively with Florida's public entities, we have designed all our services and trained our entire team around the specific mission of delivering tailored governmental insurance solutions.

A Family of Companies

Our parent company, Brown & Brown, Inc. was founded in 1939 in Daytona Beach and has since grown to be the largest insurance intermediary in Florida and the 6th largest in the world. That growth has pushed our company beyond 200 offices nationwide, housing more than 10,000 teammates. In Florida, our more than 50 offices, are comprised of 2,500 teammates responsible for the design, placement and servicing of annual insurance premiums in excess of $2.5 Billion. Brown & Brown, Inc. is a family of highly specialized units performing insurance brokerage and advisement services for clients worldwide. Below is an example of some of our business units relevant to this ITN which provide philosophical and resource support to the PRIA team.

Brown & Brown INSURANCE®

With a long-standing history of proven success, Brown & Brown is one of the insurance industry's most powerful and influential leaders.

Strategic BENEFIT ADVISORS
Integrity. Innovation. Results.

Medical, Pharmacy, Dental, Vision, ACA Compliance, Wellness, Exchange Evaluation

Hays
PART OF THE BROWN & BROWN TEAM

Employee Benefits, Property, Casualty, Liability, Risk Management

PACIFIC RESOURCES

Life, Accident, Disability, Leave Management, Voluntary, Enrollment Technology

BEECHER EVERGREEN MANAGED CARE

Solutions to help health plans, employers, and providers take control of their medical costs

herronpalmer

Absence Management Actuarial, Benefit Plan Administration, Investment Consulting

PillarRx Consulting | CUSTOMIZED PHARMACY SOLUTIONS

Managing prescription benefits by focusing on member prescription drug care to gain the most optimal cost

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Our company, publicly traded on the New York Stock Exchange (Symbol: "BRO"), recently announced an exciting partnership with the State of Florida, Volusia County and the City of Daytona Beach to build our new Corporate Headquarters in downtown Daytona Beach. This will secure for the future our place as the largest insurance broker in Florida and ensure that our company and our team remain rooted here in our great home State of Florida.

PRIA's Footprint

Public Risk Insurance Advisors (PRIA) is Brown & Brown's retail public entity specialist operation in Florida. PRIA's Daytona Beach office is centrally located to serve our Florida clients. We offer the distinct combination of a "boutique" public entity brokerage offering concierge-level service with the resources of a large national broker that allows us to negotiate better terms and conditions and create unique service plans based on our client's goals and objectives. This arrangement allows us to design, place and service in excess of $130 Million in insurance for our Florida based governmental clients alone. Our sole focus on the public entity sector enables us to provide expert consultation and guidance that will ensure our clients' will efficiently manage the volatile risks that Florida governmental entities face.

We are a completely independent agency with no vested interest in any insurance carriers or insurance trusts. PRIA operates as a truly unbiased broker/consultant with our focus solely on listening to our clients' needs and executing on their behalf.

PUBLIC ENTITY MARKET LEADERS	EXPERIENCE	CONCIERGE-LEVEL SERVICE
• 100+ Special Districts • 70+ Cities • 20+ Counties • 6 School Districts • State of Florida	• 80 Years in Business • 27 Years - Governments • $130 Million Premiums Placed - Public Entity	• Public Sector Only • Risk Management Program Design • Employee Benefits Consulting • 24 Hour Response Time

One of our core philosophies, as communicated by Mr. J. Hyatt Brown, Chairman of the Board for Brown & Brown Inc., illustrates our culture and corporate services commitment:

"The best way is almost always the most difficult way. Long term success involves conflict with those who are not disciplined or committed. Our model is designed to allow those uncommitted, undisciplined people to find other companies whose focus is not forever."
J. Hyatt Brown

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Brown & Brown, Inc. and the PRIA team are located at

220 S. Ridgewood Ave in Daytona Beach, Florida.

PRIA is proposing to do all work for the scope of this ITN from our headquarters in Daytona Beach. Additional Brown & Brown offices throughout Florida can be utilized when local resources may prove beneficial (for example, offices in Leesburg, Brooksville, Tampa, etc.). PRIA staff is proudly involved and committed to top industry organizations and professional affiliations, including:

Our Team

PRIA's teammates are **100% dedicated** to insurance placement and broker services for public entities in Florida. Our team's collective experience exceeds **300 years**, and all teammates are encouraged to continue their pursuit of knowledge by continuing educational endeavors. As a result, most teammates hold professional insurance/risk designations, including:

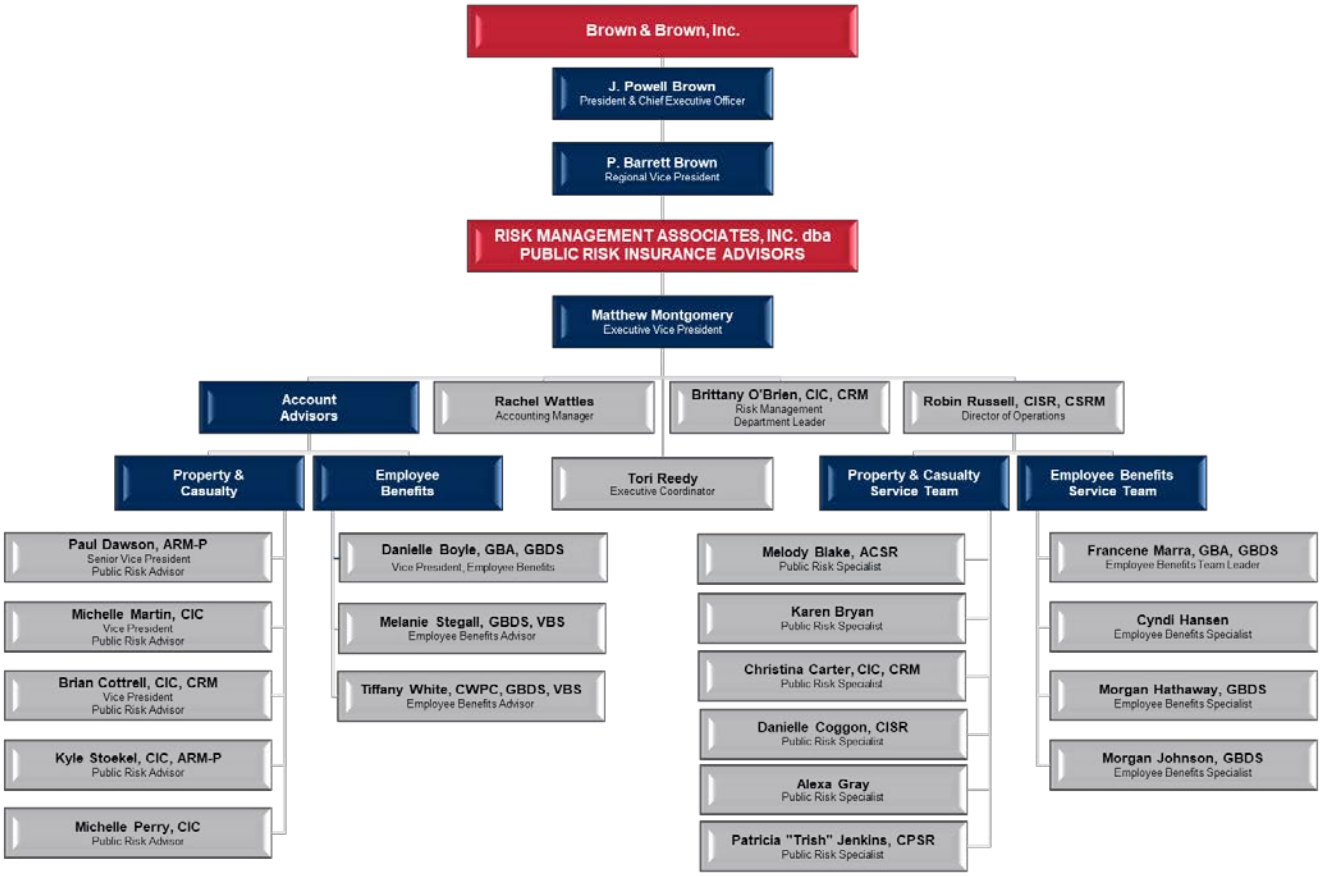
- Bachelor of Science – Risk Management/Insurance and Finance
- ARM-P – Associates in Risk Management for Public Entities
- RMPE – Completion of Risk Management for Public Entities course
- CIC – Certified Insurance Counselor
- CISR – Certified Insurance Service Representative
- CRM – Certified Risk Manager
- CEBS – Certified Employee Benefits Specialist
- GBA – Group Benefits Associate
- GBDS – Group Benefits Disability Specialist
- GWPC -Certified Wellness Program Coordinator
- VBS – Voluntary Benefits Specialist

"This is an important and distinct advantage for our team; by building a culture of dogged discipline, creating a team focused exclusively on public entities, and giving that team access to the resources and capabilities of the largest insurance intermediary in the state of Florida, PRIA has the ability to deliver unrivaled results and develop deeply meaningful partnerships with our government clients."

The entire team of insurance professionals at PRIA is cross-trained and educated on all accounts, which provides continuity and exceptional service standards. PRIA's proactive approach includes establishing a calendar of events with our clients which maintains the insurance program in real-time and assures that PRIA is aware of and available for important meetings or events. This includes communication expectations and reporting requirements. It is our service model to immediately identify and document client expectations and to meet those needs on a daily and ongoing basis.

Our publicly held Florida Corporation has been in business for 80 years and has more than $2 billion of annual revenues. As such, our financial practices are subject to strict controls. Our company is audited by Deloitte & Touche, LLP, an independent registered public accounting firm. Our conservative financial strategy maintains low leverage and strong cash generation. The most recent Annual Report for fiscal year ending December 31, 2018 is available on our website at: https://investor.bbinsurance.com/annual-reports.

4.2.2 Description of the organizational structure, including an organization chart and a chart of job categories with the total number of employees for each category. (Maximum of two (2) pages)



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4.2.3 Description of the business philosophy and management style. (Maximum of two (2) pages)

The Brown & Brown organization is a team of independent insurance intermediaries designed to help organizations of all sizes. Our strength lies in our specialized, focused approach that provides you a comprehensive, seamless solution.

Founded in Florida more than 80 years ago, Brown & Brown employs thousands of Floridians and operates out of the corporate headquarters located in Daytona Beach, Florida. Brown & Brown is the largest insurance intermediary domiciled in the State of Florida and is a publicly owned corporation traded on the New York Stock Exchange.

Nationally, Brown & Brown's public entity footprint is immense, with more than $150 Billion in total insurable values (TIV) represented by our team of insurance professionals. This has been accomplished by balancing our strong local and state presence with corporate expansion into national and international insurance markets. Brown & Brown provides world class insurance services and product offerings to public entities of all shapes and sizes.

PRIA has focused exclusively on the risk management and insurance needs of Florida's public entities since 1992. Since that time, Brown & Brown's Public Entity business has grown to include more than 250 of Florida's governmental entities. Notable Florida public entity clients include 70 cities, 6 public school districts, 21 counties and 5 public universities. The PRIA team is comprised of 20 insurance professionals collocated with the corporate leadership team in the Daytona Beach Corporate office.

We go beyond traditional insurance transactions to provide a unique experience because we believe that risk management and employee benefits without passion, innovation and accountability is just buying insurance.

- We have complete market access to all worldwide insurance markets.
- We have strong individual carrier relationships at all levels, including the C-suites.
- Our operational model allows our clients complete access to top-tier resources without complicated political structures.
- Our evaluation of exposures in the pre-underwriting stage and quality of submissions results in a Quote-to-Bind ratio of around 40%, compared to the industry average of 15% to 18%.
- We have total flexibility to use the best insurance providers, vendors, resources, foreign brokers, wholesalers, claims attorneys and forensic accountants that create a "best in breed" solution.

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4.2.4 A list of complaints related to the service(s) the Respondent is proposing to provide, that have been filed with the State Insurance Commissioner's Office during the ten (10) years prior to May 1, 2019, including the nature of the complaint and the disposition.

Public Risk Insurance Advisors has had no complaints during the last ten years.

4.2.5 Identify any existing provider relationship that may prevent you from acting independently and providing objective advice and guidance. (Examples include overrides, commission agreements, preferred contracts, pricing based on volume, etc.)

None.

4.2.6 Provide all Respondent policies and procedures relating to the services the Respondent is proposing, including, but not limited to conflicts of interests; receipt of contingency compensation from provider; internal and external audits of Respondent; employee training concerning the duty of care and full disclosure owed to Respondent's clients.

PRIA has no conflicts of interest and will not accept contingent compensations. Any compensation paid to PRIA outside of the agreed fee or commission structure dictated by this bid contract will be returned to the District.

Our parent company, Brown & Brown, or its Affiliates, may receive contingent payments or allowances from insurers based on factors which are not client-specific, such as the performance and/or size of an overall book of business produced with an insurer. Such contingent payments or allowances are not subject to this Agreement and will not be credited against the balance of any fee owed to Broker pursuant to this Agreement or paid to the District.

4.2.7 Describe what makes your organization unique from other organizations that may provide the same services.

PRIA is uniquely qualified to meet and exceed the service needs of the District. Our proven track record of delivering superior results speaks volumes for our ability to deliver in the future. With over 250 Florida public entity clients, we are the largest and most proficient Florida Broker whose core business is Public Entity Insurance and Risk Consulting. We have solely focused on the public entity sector for over 27 years and our experience and consultative abilities are unmatched by any other broker.

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Abilities and characteristics that make PRIA unique:

- 100% Dedicated to Public Entities in the State of Florida
- Access to 10,000 teammates worldwide within our Family of Companies which provide our team with guidance on industry trends. This includes our sister companies which represent Fortune 100 clients and 100,000+ life groups.
- $43 Billion in TIV under management.
- Complete access to and critical mass with, all competitive markets including Preferred Governmental Insurance Trust (*Preferred*). Many brokers do not have access to this key public entity insurance specialist. We rarely use wholesale brokers to access markets which further reduces our client's cost by eliminating the "middleman". Our high premium volume with all competitive markets, including excess workers' compensation markets and public entity insurance specialists, enable us to design the most efficient insured and self-insured programs.
- History of designing and delivering the most competitive and efficient risk management and benefits self-insured programs. A review of our references will show that our program design and recommendations do not remain stagnant. We routinely measure risk retention and risk transfer options to ensure that the most cost-effective balance of self-insurance and insurance is maintained.
- History of seeking and providing proactive solutions. We have consistently provided both short and long term, strategically sound, Employee Benefits, Property, Casualty and Workers' Compensation solutions that have saved our clients millions of taxpayer dollars.
- Ability to reduce the District 's cost of risk and not just the cost of insurance. Our consultative services are one of our strongest areas of expertise.
- For example, we have lowered our clients' risk exposure by establishing contractual insurance requirements and reviewing their vendor and contractor agreements.
- Uniquely proficient in all areas of public entity risk management and consulting.
- We offer a unique and robust array of analytical resources as well as loss control and training resources at no cost to the District.
- Our large client retention rate is 98% - This is testament to our ability to manage complex risk management programs and maintain our clients' trust and confidence in us.

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4.2.8 Provide the total number of clients that Respondent currently provides services to for the proposed brokerage services in this ITN; and the number of those clients that are Florida public entities. (Maximum of one (1) page)

The following list of clients are all Florida Public Entity clients. This list includes those clients that are similar in size, functionality, and complexity to the District.

3 Water Management Districts

- Southwest Florida Water Management District
- St. Johns River Water Management District
- Suwannee River Water Management District

35 Florida public entities with self-insured casualty and/or workers' compensation programs

30 Florida public entities with total insured property values of $100M or higher.

17 public entities with self-funded medical programs.

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4.3 ABILITY TO PROVIDE REQUIRED SERVICES.

Overall ability to provide the services required in Part III, A. Health Insurance Broker and/or Part III, B. Property and Casualty Broker and/or Part III, C. Workers' Compensation Broker of this ITN based upon specific experience, expertise and performance history.

4.3.1 Description of Respondent's contractual relationships, if any, with organizations or entities necessary for the implementation of the response (i.e., actuarial services, data information services, etc.). (Maximum of one (1) page per entity or organization described)

A. Health

PRIA does not have any contractual relationships outside of the Brown & Brown family of companies that are necessary to the successful implementation of the scope of services requested in this ITN. We have access to many outside resources that may add value to the District where compliance and education are concerned. For example, Miller Johnson, P.A., an ERISA / ACA attorney firm, HR Workplace Services and Zywave, both HR assistance and employee education resources. However, these are annually reviewed partnerships that are available at no additional cost and will not disrupt the implementation or ongoing administration of the District's employee benefits program. Additionally, we do not consider utilization of these resources outsourcing of any scope of service requirements.

B. Property & Casualty and C. Workers' Compensation

PRIA does not have any contractual relationships outside of Brown & Brown that are necessary for the implementation of the services requested in this ITN. We do have outside resources available to the District specifically for training, education and analytics but none of these are considered outsourcing of any of our service deliverables. For example, the District has access to a Web based asset management tool (AMP) that PRIA licenses from AssetWorks. AssetWorks is a fully independent professional appraisal company with a unique asset management software.

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4.3.2 Describe the Respondent's general approach and philosophy regarding communication and customer service interaction with clients. (Maximum of two (2) pages)

Our philosophy on all matters is to communicate proactively and not wait for client's inquiries. Whenever possible we inform clients of pending issues, potential issues, market and loss trends, emerging exposures, and new insurance markets. Because of our critical mass in the Florida market we are also able to share risk management techniques of other public entities. This would include common insurance limits purchased, self-insured structures and loss experiences of similar entities.

The most popular and effective method of communication with our clients is email and phone. We also conduct in person meetings, educational workshops, webinars and seminars for our clients. We attend and participate in many annual conferences to stay current on all relevant issues. We are good standing members of the following organizations and attend their annual conferences and/or periodic meetings:

- Florida Association of Special Districts
- Florida Public Risk Management Association
- Risk and Insurance Management Society
- Florida City and County Manager's Association
- Florida Public Human Resources Association
- Florida Association of Counties
- Florida Government Finance Officers Association

We subscribe to several insurance news agencies that provide daily updates on current events, breaking news and potential changes affecting insurance professionals and their clients. Relative stories and reports are provided to clients with summaries and explanations of relevance.

A. Health

PRIA's philosophy is to proactively keep our clients as informed and educated as we possibly can. We keep our clients at the forefront of compliance, legislative and industry trends, updates and issues by meeting with them in person, providing newsletters, webinars and educational materials as often as necessary. This ensures we can prepare for any upcoming changes/updates that may have an impact on their employees and/or benefits and wellness programs.

PRIA utilizes a team approach to ensure we provide the best customer service experience possible. We assign an executive management team to each client consisting of a Team Lead, a day-to-day Employee Benefits Advisor, a day-to-day Employee Benefits Specialist, an Analyst, a Marketing Specialist, as well as backup personnel. This team is responsible for the day-to-day customer service, claims and billing issues / resolution, short and long-term strategies, renewal process management, open enrollment and implementation assistance, health fair event management, compliance / industry updates. PRIA commits to communicate in ways that are most beneficial for the District. As stated above, we typically communicate with our clients via in-person meetings, email, phone, newsletters, webinars and additional educational materials.

The District's assigned Employee Benefits Team:

Team Leader	Danielle Boyle
Employee Benefits Advisor	Melanie Stegall
Employee Benefits Service Team Leader	Francene Marra
Analyst	Brandon Savage
Marketing Specialist	Morgan Johnson
Backup Personnel	Morgan Hathaway Cynthia Hansen Tiffany White
Director of Operations	Robin Russell
Executive Vice President	Matthew Montgomery

B. Property & Casualty and C. Workers' Compensation

Industry Trends & Risk Management Issues – We understand that our clients' plates are generally full of issues and problems unrelated to the insurance industry. Therefore, we continuously communicate with our clients regarding the changes and conditions in the industry that affect them. We maintain strict vigilance of all things affecting risk management programs including legislative changes, rate trends, emerging claim trends, court precedents and new markets. We believe that this information is critical for risk managers and strive to stay current and many times, ahead of trends and issues.

Any information that we gather is shared immediately with clients in anticipation of adjustments to programs, loss funds, safety training or budget estimates. Our most commonly used method of communication is email. Examples of communicating with clients on important news are summarized below.

- PRIA sends each client a Weekly Rundown: News for Risk Managers. This weekly industry news brief is assembled by PRIA specifically for Florida risk managers.
- PRIA sends periodic white papers to risk managers on current trends and emerging risks. These documents provide more detail on risks and solutions. Recent topics include property market trends, cyber security updates, and a paper on ADA website compliance lawsuits.
- We maintain active oversight of the legislative sessions to track bills that are introduced that may affect our clients risk management programs. For instance, Senate Bill 1072 was introduced in 2019 calling for higher sovereign immunity limits ($300k/$500k). Fortunately, the bill did not make it out of committee hearings but if introduced again in 2020 we will alert our clients.

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To maintain knowledge of changes in Federal and State regulations we use industry watchdogs, daily email alerts and have regular contact with Tallahassee insiders.

We will also meet with the District well in advance of renewal dates to discuss market conditions and other factors influencing insurance terms and conditions. This information is vital to our clients' ability to communicate potential changes (both good and bad) in their risk management programs effectively and intelligently to their respective elected officials and upstream managers. We understand the current economic climate and the strain that it has put on budgets and personnel. Our objective is to communicate quickly and effectively all relevant information that our clients will need to plan for the future and make informed decisions in a timely manner.

Customer Service Interaction – Each client is assigned a specific Team Leader and Support Staff as well as backup personnel for each discipline. Our client interaction philosophy is to be very proactive and anticipate service needs to reduce your administrative burden. Our desire is to be a linear extension of your risk management department and take ownership of your objectives and challenges.

Our service team is specifically trained to anticipate the next item on the service timeline during the policy year and the renewal period. They are provided a thorough checklist, which includes the scope of services defined herein and those that may rise to the level of importance deemed by the client. This checklist is a guide that is to be strictly adhered to. Each member of the team is held accountable to our corporate wide quality control standards. Checks and balances have been established in our organization that allows for multiple team members to be aware of upcoming needs of an insured. Our timeline provides ample opportunity to be ready for the unexpected as well as delivering renewals and other important items in a timely manner.

Your Team Leader, Paul Dawson, meets with the service staff regularly. We send systematic reminders to clients regarding outstanding items and work closely with them to obtain underwriting data to ensure our quote, proposal and meeting timelines are adhered to.

Team Leader	Paul Dawson
Primary Customer Service Rep	Trish Jenkins
Claims Specialist	Alexa Gray
Backup Personnel	Michelle Martin Melody Blake
Director of Operations	Robin Russell
Executive Vice President	Matthew Montgomery

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4.3.3 Describe how the Respondent will maintain the confidentiality of District records and data, including but not limited to, any security procedures for accessing, sending and storing data that are currently in place.

A. Health

PRIA places the utmost importance on protecting our client's data and records. All client data, including claims data, records and client communications are housed in our Agency Management System, AMS360. PRIA also utilizes a shared drive that is maintained in a secure cloud environment. PRIA has access controls in place to ensure our client information is only accessible by individuals with proper credentials.

In addition, PRIA regularly communicates with our vendor partners and clients using secure emails as well as password protecting documents to ensure security. Our team is also HIPPA compliant and completes annual training to ensure proper handling and security of personal health information.

B. Property & Casualty and C. Workers' Compensation

Our Agency Management System, AMS 360, and other Quality Control guidelines ensure that all client communications, data and records remain confidential. All employees are trained annually on the Public Records law (F.S. 119) as well as HIPPA and related records management protocols. Brown & Brown has a Quality Control division which includes multiple teams of internal auditors. These auditors perform not only financial audits, but also file and Information Technology audits of each office to assure funds, records and client service are performed in accordance with the company's policies and procedures. The results of these audits are made directly to Brown & Brown's Board of Directors. In addition, we have corporate standards, including procedures such as: Catastrophe Plan, Contract Review standards, Internal Procedures Manuals, Correspondence Management, Data Retention, etc.

4.3.4 Describe in detail your administrative capabilities on compliance issues

A. Health

Employee Benefits compliance has become one of the most complex challenges facing employers and is where PRIA can add tremendous value. Since the implementation of the Affordable Care Act, employers are turning to us more than ever to keep them informed and to assist them in complying with all DOL requirements.

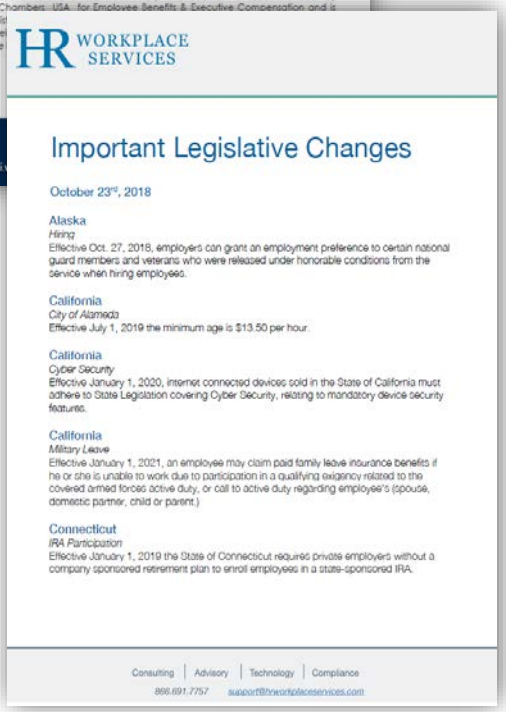
Brown & Brown / PRIA has recognized this challenge facing our employer clients, and in turn, has devoted substantial resources into developing solutions for addressing the ACA requirements. We have hired Miller Johnson, a highly regarded ERISA/Employee Benefits Compliance firm, to be on retainer specifically to provide guidance as it is released and to answer questions that arise.

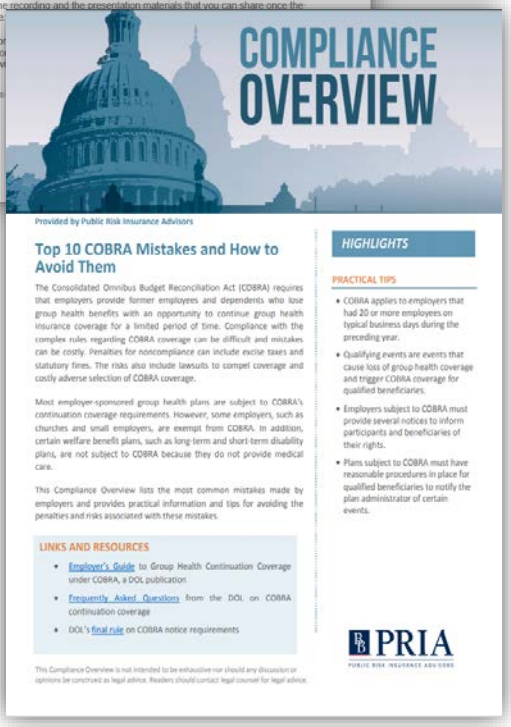
In addition to ACA Compliance, any time a client has a benefit related legal question, we email our attorneys at Miller Johnson and forward their legal opinion on the matter to the client. These responses are generally within the same day and add significant value. Should changes in

regulation impact the District's employee benefits program, we will work with Miller Johnson to ensure you are educated on the matter as early as possible and a plan is established for compliance moving forward.

For some of the less complex HR / compliance questions, we have additional resources such as HR Workplace Services and Zywave, which also provide guidance for our clients.

In addition to having the above resources available for specific questions and issues, we frequently advise our clients to attend the webinars that are hosted to proactively ensure compliance. We periodically send out newsletters and communications to keep our clients at the forefront of any legislative and/or industry updates.





B. Property & Casualty and C. Workers' Compensation

The lion's share of compliance issues resides in the employee benefits arena. However, there are numerous statutes and regulations that affect property, casualty and workers' compensation programs. Below are a few regulatory areas that can dictate procedures in Property, Casualty and Workers' Compensation:

Cyber Liability

Notification rules for potential data breaches are regulated by each State. We are familiar with these requirements and advise our clients accordingly. We are able and prefer to meet with our client's respective IT departments to ensure that IT and risk management departments are in sync with these requirements as well as the notification rules in insurance policies.

Property and Casualty

There are few compliance issues within these insurance coverages. Regulations that affect liability risks and insurance include the State Sovereign Immunity Law (FS 768.28) and especially the State Supreme Court case regarding sovereign immunity waivers (Home Assurance v National Railroad). We are intimately aware and proficient in counseling our clients in reducing their exposure to liability above the State tort cap.

Specific to the District's liability exposure is FS 373.1395, Liability limitation on public land use.

Workers' Compensation

Most regulations governing the administration of workers' compensation programs are well known by claims handlers. However, we are also proficient in understanding the benefit structures that govern WC claims. We can also provide consultation on the Federal workers' compensation laws specifically the USL&H and Jones Act. These distinct laws govern the benefits that employees receive for work performed adjacent to navigable waters (dock building, water control structure building, etc.) and a crew of a ship. The Districts employees are not subject to the USL&H law, but District contractors are.

Public Records Law

Compliance with the State's public records law (FS119) can be a component of claims administration. We assist many clients with requests for documents related to open and closed claim files. For example, claim files maintained by risk management departments would not be public record until all litigation and settlements are final.

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4.4 DELIVERY OF CLIENT SUPPORT AND ASSISTANCE

4.4.1 Describe Respondent's analysis methodology of the direction and priorities of the District's employee Health Benefit and/or Property and Casualty and/or Worker's Compensation insurance to determine recommended changes and project future trends. (Maximum of three (3) pages)

A. Health

We are always exploring new, innovative ways to save our clients' money. As the 6th largest insurance broker in the world, we are the first to be introduced to new insurance products. We also invest in an innovation hub wherein new insurance related tech companies receive funding to develop the products and services of the future. Brown & Brown even incentivizes our own employees to develop innovative insurance services so that we can be the first to deliver them to our clients.

The team we have assigned to the District is committed to working with the HR and Risk Management teams to develop a comprehensive strategy to save the District money over the short and long-term. We understand that as your consultant, we are trusted to recommend solutions that are not only in your best interest, but that will put you in the best financial position to offer a robust employee benefits program to your employees, retirees, and their families.

Our methodology would begin with a collection of your current benefit plan designs, policies, contracts, claims history, and employee demographics. From there we would benchmark the District as compared with your peers regionally, within the State of Florida, and nationally. We understand that your employee benefits program is a significant portion of the total compensation that is offered to your employees; therefore, you need to provide above benchmark benefits in order to attract and retain talent.

We would then perform an extensive analysis on the District's claims in order to establish a budget projection for the upcoming plan year and the subsequent plan year. Our actuaries and consultants will explain our methodology and offer ideas for cost reductions wherever possible.

Our in-house actuaries and analysts will identify utilization trends on a monthly and quarterly basis and make actionable recommendations based on your data.

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B. Property & Casualty and C. Workers' Compensation

As mentioned in our response to 4.3.2, we stay current with trends and market changes through multiple sources of information. PRIA is the largest Property and Casualty Public Entity focused broker in Florida. Consequently, we are completely immersed in this sector with our finger on the pulse of any change in the industry. We never shift gears to focus on general insurance for the private sector, personal lines or other distractions.

Our analysis methodology involves a detailed and structured identification of current and future loss exposures. We assess our client's exposure to risk in many ways and degrees of intensity. Methods vary from detailed property appraisals to comprehensive continued-operation studies. We use risk identification and exposure analysis as the foundation of our risk management program design and recommendations. This process is used to design and implement insurance and self-insurance programs as well as continuous measurement of the effectiveness of these programs. Any recommendations for program designs, loss control, safety training, or new insurance policies are presented in written form with analytical support. We provide objective and subjective analysis so that the District can make informed decisions.

We have extensive experience with the analysis of all exposures that local government's face including but not limited to:

Property

We run an RMS and AIR Probable Maximum Loss (PML) model for each large client and evaluate the large loss centers and the flood probabilities. We will provide the District with current RMS and AIR catastrophic modeling results at each property renewal to ensure that the insurance loss limits are adequate and will be considered "reasonable" by State regulators.

We make sure to collect detailed property data relative to wind resistance for all locations. Our process involves identifying the roof covering, roof geometry, roof age and roof strapping (if any) of these locations. This additional data greatly increases the accuracy of PML models and in turn better identifies and measures an insured's exposure to loss. It is also a tool used to negotiate better terms and conditions with carriers. Without the additional roof information, the PML model will default to a higher value and thereby increase the PML value resulting in higher premiums.

We also utilize an interactive catastrophic modeling tool that can customize potential property loss outcomes in real time. **Touchstone** is new technology available to the District at no additional cost. More information about this resource can be found in Section 7, Additional Information.

Analysis of flood exposures is critical. FEMA will not provide public assistance for flood losses to structures that are in a High Hazard flood plain (Zones A and V) unless coverage is purchased through the National Flood Insurance Program (NFIP) or the commercial marketplace.

Consequently, we determine flood zones for all locations on an annual basis. Structures that are in A or V zones should be insured with NFIP or commercial policies at appropriate levels.

The requirements that bond companies may have in place are also reviewed to ensure that the property insurance program meets those requirements.

We also evaluate the need for and the proper levels of often overlooked property coverages such as: extra expense, contingent business income, boiler & machinery, increased cost of construction, building ordinance, equipment floaters, demolition costs, debris removal, utility interruption, pollution clean-up, sewer back up, property-in-the-open, etc.

We accomplish all the above through various techniques, processes and tasks such as:

- Property Site Inspection
- Building Appraisals
- Catastrophic wind, flood and storm surge models
- Interviewing Key Personnel
- Internet Research (District's website and local sites)
- Financial Record Research (CAFR, Budget)
- Loss Run Reports
- Current Program Analysis and Review (Coverage Forms and Policies)

Workers' Compensation

Methods include review of loss run reports, financial reports, actuarial reports, incident reports and interviews with key personnel and management. We also review the return to work programs, disciplinary procedures and safety programs that are currently in place. Analytics play a large role in rate determination and retention levels. Internally we evaluate numerous factors, trends and total cost of risk values to determine the best risk retention and transfer levels that minimize the District's financial exposures both long and short-term.

Liability Loss Exposures

Thoroughly identifying these exposures can be complex due to the broad litigious nature of citizens and businesses. However, we have seen many types of lawsuits and possess an intimate knowledge of the State and Federal Statutes that govern public entity operations and personnel.

Consequently, our advice, counsel and recommendations are based on actual claims experience occurring here in Florida and many years of assisting other clients with similar issues.

For example, we are familiar with the State Statute that limits the District's liability from losses that occur on District lands when access is provided for recreational use (FS 373.1395). PRIA has managed the liability insurance program for 3 Water Management Districts for over 15 years and we have used our knowledge of this statute to reduce insurance premiums, mitigate claims, and consult on third party contracts.

The basic methods of identifying exposures include: review of loss reports, review of financial reports, review and understanding of all operational functions, evaluating current and future contractual obligations, identifying key personnel, reviewing lease contracts, reviewing the District's policies and procedures manuals and general practices, etc.

4.4.2 Describe Respondent's approach and methodology for gathering information on current market trends and legislative developments used to assist clients in developing a strategic employee Health Benefit and/or Property and Casualty and/or Worker's Compensation insurance. (Maximum of three (3) pages)

See 4.3.2 and 4.4.1

4.4.3 Describe anticipated involvement in the District's annual provider selection or renewal process, including regarding process timeframes, negotiation of rates and provider selection. (Maximum of three (3) pages)

A. Health

Renewal Process and Timeframe

Prior to any renewal information being received, PRIA typically holds a pre-renewal meeting with the District as well as the insurance committee, if desired. During the pre-renewal meeting we will discuss current coverages, what the District likes and dislikes about the current program as well as anything additional they would like to see. For securing services and lines of coverage which require formal Request for Proposal process, PRIA will collaborate with the District to review all claims, utilization, pharmacy, benefit summaries, renewal projections, plan design, etc. to strategize and develop appropriate specifications. Our team will draft a proposal including all agreed upon specifications and will submit to District Staff for final submission to carriers. Once approved, PRIA will release the RFP to the carriers and will grant them 2-3 weeks to submit their responses (if time permits). Once all responses are received, PRIA will review and analyze submittals and present results with our recommendations to Staff and the District Board.

Below is a sample timeline for the renewal marketing process:

ACTION	PRODUCTION TIME (To Effective Date)
Begin planning process / Pre-Renewal Meeting Renewal Questionnaire Data Collection – Census, Questionnaires & Current Carrier Invoices Received	150 days prior 150 days prior 120 days prior
RFP out to carriers	120 days prior
Employee Enrollment o Online enrollment o Open Enrollment Meetings o Enrollment forms collected	 30 days prior to Open Enrollment 60 days prior 45 days prior
COBRA rates updated Policy documents delivered	45 days prior 30 days after the effective date

***This timeline is customizable based on the required scheduled open enrollment and Board approval.**

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PRIA will perform the annual market analysis to obtain formal quotes for medical, dental, vision, life, long-term and/or short-term disability, Employee Assistance Program, flexible spending plans and other supplemental benefits as directed by the District. We routinely conduct formal bids for all benefit programs including administrative services such as Online Enrollment systems.

Once renewal proposals are received from our carrier partners, PRIA enters them into a proposal format and presents to the District and the insurance committee for review. We will highlight advantages and disadvantages of each proposal option as compared to the in-force and renewal proposal. Our market presentation will also include: AM Best ratings, a market summary showing all carriers that responded to the RFP and plan options for each line of coverage. PRIA will recommend finalists to staff and the insurance committee for discussion and selection. We will then begin final negotiations with the chosen carriers. **Please see Section 7: Additional Data for a Sample Marketing Proposal.**

Negotiation of Rates

PRIA will use our negotiating influence with the insurance carriers to ensure the District receives the most competitive rates available in the market. Negotiating renewals for our clients is a core competency of the Health and Welfare practice of PRIA. Our staff includes many former insurance underwriters with firsthand knowledge of how these renewals are developed. We will negotiate the best financial arrangement possible for the District using our knowledge of underwriting requirements and leverage our relationships with the carriers.

We have more business with the insurance carriers in the state of Florida than any other broker. This gives us preferred status with the insurance companies. We have dedicated support staff in the home offices of all the carriers and access to their underwriters at renewal; therefore, we have more leveraging ability than any other broker as it relates to policy terms, rates and plan design. One very important distinction between our market leverage and other brokers is that we actually use our leverage. Many brokers do not market their groups yearly. Even if the client is not interested in changing insurance companies, we still send every group out to market to provide us with competitive data to ensure the best plans are in place with the best pricing.

It is our mission to utilize market forces and competition in the marketplace in the pursuit of competitive insurance placements for our clients every year. This concept underlines one of our core business principles: ***Always do what is right for the client***. We are constantly focused on the balance between holding the market's interest while simultaneously conducting competitive processes in a professional manner.

The volume of business and insurance premiums that Brown & Brown places with major carriers in Florida and the U.S. has propelled us to preferred status with nearly every insurance carrier in the market. Thus, we receive a wealth of enhanced services that are advantageous for our clients.

These services include but are not limited to:

- Dedicated support staff to address billing and claims issues
- Access to underwriters at renewal
- Enhanced negotiating power

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Network Analysis

PRIA frequently analyzes provider networks for all carriers that we utilize. If our clients have a specific provider that is used but not in network, we work very closely with the carriers to explore all options and possibilities to ensure the employees can have access to quality providers. Continually analyzing provider networks and maintaining superior providers is of the utmost importance to ensure our clients and their employees continue to have access to excellent care for minimum out of pocket costs.

During the marketing process, we will perform a network analysis for a specific radius to ensure the desired providers are included. If the desired providers are not in-network with a particular carrier, we can explore other carriers and complete a network disruption report to ensure the least amount of disruption and inconvenience both administratively and to the employees.

If it is necessary to change carriers, PRIA works extremely close with our clients and the carriers to ensure we match coverages as closely as possible or enhance benefits and lower costs. We will manage the implementation process to ensure a smooth transition for the employees as well as the HR team.

B. Property & Casualty and C. Workers' Compensation

Our technical approach to the renewal process can be broken down into 4 categories; **Client Vision, Risk Assessment, Market Research & Negotiation, and Insurance Placement.**

Client Vision

First and foremost, our responsibilities begin with listening to our clients to understand the history of the risk management program, future goals, budget constraints, program design needs and desires, and risk tolerance. Designing an effective risk management program must involve the input of each client's decision makers and this is where we start, every time. We will conduct a pre-renewal meeting to establish your vision.

Risk Assessment

Insurance placement and risk management efforts which are long on value and short on surprises are based on understanding the nature of the risks themselves. When PRIA onboards a new client, we collect and affirm scores of data points which will later underlie advantageous program design and underwriting. This data collection includes but is not limited to; property appraisals, construction types, roof types, flood mapping & audits, schedule review, auto valuations, cyber liability analysis, workers' compensation class code review, workers' compensation modification factor audit, and an Insurance Coverage Review for all lines of insurance. PRIA will collect this data independent of the District's assistance whenever possible to relive your administrative burden. All data will be shared with the District for verification prior to final underwriting data is submitted to markets.

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Market Research & Negotiation

As public entity specialists with many clients similar in size and scope to Southwest Florida Water Management District, PRIA has a natural working knowledge of the relevant insurance marketplace. Beyond that inherent knowledge, we will work with the District to further research the market each year to bring all options to the table at each renewal. Once we have agreed on a path forward, PRIA will leverage our market clout to drive rates down on behalf of the District while simultaneously securing terms necessary for a successful program. A review of our prior work history in 4.4.9 shows that prowess in the marketplace yields better results than our competitors can bring.

Insurance Placement

After negotiations and decisions have been made, PRIA will secure the placement of all insurance policies, check all binders and policies and deliver them directly to the District staff.

Following is a suggested timeline and workflow.

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GENERAL WORK FLOW SCHEDULE

120+ days prior to policy expiration

- Initiate Marketing Process
- Current market conditions analysis
- Estimate Pricing
- Discuss Budget Constraints and Goals
- Written request for underwriting data
- Assist in collection of risk exposure information
- Establish competitive markets to be approached
- Identify desired coverage, terms and conditions goals
- Provide written premium estimates for all coverages.

90 to 120 Days prior to policy expiration

- Scrub Statement of Values
- Approval of Submission by client
- Submit all underwriting data to chosen and/or all interested carriers
- Update risk management on progress and early pricing indications

60 to 90 days prior to expiration

- Written summary of quotes received, and markets responses
- Provide Premium Comparison with expiring and renewal terms.
- Include Cost of Risk Analysis
- Obtain Catastrophic Modeling Results
- Develop recommendation for most effective program

30 to 60 days prior to expiration

- Attend Meetings and Workshops
- Assist in preparation of Board Agenda items
- Complete required signed documents
- Submit Requests to Bind to chosen carriers

Inside 30 days prior to expiration

- Request, Review and Issue Binders
- Issue any recurring Certificates of Insurance
- Issue Invoices

30 to 60 days after policy inception

- Re-issue any expired binders
- Review, correct and issue policies
- Provide an annual summary of program terms and premiums.

Ongoing

- Daily Policy Maintenance and Client Service Requests
- Claims Advocacy and Handling
- Large Claim Reviews
- Property appraisal management and implementation
- Update and Scrub Statement of Values data
- Stewardship Report
- Review Risk Management Polices
- Inspection/Loss Prevention Program Implementation
- Flood Zone Audits for Property
- Market Trend and Emerging Markets Identification
- Legislative Change Tracking
- Industry News Communications
- Other Special Projects as agreed

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4.4.4 Describe Respondent's process for assisting clients in the selection of an employee Health Benefit and/or Property and Casualty and/or Worker's Compensation insurance vendor. Explain experience and expertise that would specifically benefit the District in this process

A. Health

PRIA has significant experience in advising and guiding our clients through the Health Benefits Insurance Vendor selection process from start to finish. We regularly manage the Request for Proposal (RFP) process for many of our clients from beginning to end, if requested. Our RFP's are written to address the needs and objectives of each individual client and each specific benefit program. We encourage our clients to review the RFP before it is released to ensure that all critical components are included. We ask bidders to be concise and direct in answering specific questions without providing extraneous content. We have found that this overall approach makes RFP processes much more effective as we are better positioned to compare bidder responses and evaluate criteria specific to each client.

Our proposal analysis is a process of reviewing each bidder's response and interpreting its meaning, and then comparing the responses across all bidders. The financial analysis is certainly easier to quantify and compare, but the narrative is imperative in exploring both what a supplier can do, how they can demonstrate their effectiveness, and what commitments/guarantees they are willing to make regarding their services and performance.

We negotiate contracts on behalf of our clients frequently, including through renewal negotiations, during RFP processes and on an ad-hoc basis. PRIA will be responsible for managing the final contract negotiations and implementation process (if necessary) at the completion of any project. PRIA will ensure a contract is consistent with what was agreed upon by client and vendor and lead the review and signature process in support of your Benefits/HR and Legal teams. With any new client, we also review in-force contracts to determine if there is any room for enhancements.

The consulting team assigned to you has significant experience in negotiating best in market deals for our clients. Our team is comprised of seasoned consultants with previous underwriting and actuarial experience.

Performance guarantees are critical to the vendor selection process and can be a key differentiator. We work with our clients to understand their unique business objectives and develop custom performance guarantees to ensure all vendors are financially accountable to their service level commitments. We believe performance guarantees should be based on metrics specific to the client, not the vendors' book-of-business or larger pool. Our approach is to engage the vendor/supplier in a discussion of the client's priorities and expectations, and to encourage them to draft guarantees that will reflect their commitment to support those priorities and meet/exceed those expectations. PRIA will then benchmark their proposed metrics against what we consider best-in-market criteria for our clients.

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As public entity specialists, our marketing team is uniquely positioned to assist the District in soliciting proposals for the various lines of coverage while adhering to Florida Statutes regarding public entity procurement. We will develop comprehensive Requests for Proposals to ensure all important items are addressed resulting in proposals that contain all information vital to make an informed decision.

The following is an outline of the key aspects of a bidding process that PRIA would expect to perform for a client:

- Develop an RFP for procurement of the applicable services with an appropriate understanding of your goals and objectives.
- Issue RFP to the marketplace and interact with vendors throughout the RFP process.
- Conduct an analysis of proposals and prepare a written report for the client. The report will:
    - Compare major quantitative and qualitative aspects of each vendor's proposal (i.e. financials and guarantees, member and account service, technology, communication capabilities, etc.);
    - Highlight any concerns and determine which vendors can be eliminated; and
    - Recommend vendors to be considered for finalist interviews and site visits if necessary.
    - Once finalists are selected, develop an agenda and formulate questions for finalist interviews and reference checks.
    - Attend and facilitate finalist interviews and site visits if necessary.
    - Require finalists to submit best and final offers, based on identified criteria.
- Negotiate final terms of agreements with finalists, including fees, performance guarantees, scope of services and any other relevant terms and conditions of their contract(s).
- Develop final recommendations for the client's review and approval.
- Support implementation of new vendor and any new plan/program provisions, including detailed review of contract.

To assist the District in selecting quality health insurance vendors, PRIA will provide a detailed analysis within formal reports that include comparative data and subjective analysis. We also commit to assisting, if necessary, with the interview process with short listed vendors.

B. Property & Casualty and C. Workers' Compensation

The evaluation of potential insurers is a vital function of our renewal process and includes subjective and objective criteria of each insurer. We have over 27 years of experience with public entity insurers and possess significant hands-on experience with carriers' abilities and track records. The "staying power" of carriers in Florida is vitally important. Throughout the years many insurers have fled the State or altered their risk appetite after large catastrophic losses or changes in State law. For example, many property carriers dramatically altered their risk appetites after the catastrophic losses in 2004, 2005 and to a lesser degree 2017 and 2018. We evaluate property carriers based on their history of resiliency to large losses as well as their claims handling record. We are careful not to align our clients with carriers that have performed poorly in the past even if their current pricing is aggressive.

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We also analyze coverage forms to ensure that our clients have the very best coverage terms available. We negotiate broader terms at nearly every renewal and offer custom language to the benefit of our clients.

The availability of loss control and safety training resources that insurers provide can also be of critical concern. The District's current liability insurer brokered by PRIA, Preferred, provides many valuable training and loss control resources at no cost to the District. When other liability insurers are considered the value of loss control and safety training would be evaluated.

Even more important than determining the strength of a carrier is the broker's ability to access all carriers. One of PRIA's core competencies is our knowledge of and relationship with all competitive insurers. Our marketing process and philosophy is somewhat unique and can be summarized as follows:

Do business with as many insurance markets as possible. Do not simply offer renewal and accept pricing from the same company year after year and limit our clients' options – be sure that we are getting the best deal for our clients every year.

We believe that an agent's job is to utilize market forces and competition in the marketplace to be sure PRIA brings the most competitive insurance placements to our clients every year. This concept also underlines one of our core business principles: *Always do what is best for the client.* We have learned how to keep the markets' interest while conducting a competitive process in a professional manner. Our companies **trust** us. So, we maintain excellent market relationships – ALWAYS - in hard, soft, or stable markets. We are experts in designing and implementing custom insurance programs. One of our core strengths is the ability to negotiate and obtain the inclusion of innovative coverage terms from carriers resulting in custom policies aimed at a client's specific risk needs. Our clients have benefitted from this approach in the past specifically in the many custom enhancements implemented in many of our property policies.

Our practice before recommending and implementing specific policies includes the written evaluation of the terms and conditions presented by insurance carriers. Our evaluation is generally presented in a spreadsheet or narrative format with objective criteria of each carrier quote compared with all other competitive quotes. Subjective criteria are also provided and includes the claim handling reputation of a carrier, insurers' financial security, length of time in the Florida marketplace and the probability that a carrier will assist the District if a difficult claim arises. Our goal is to align the District with insurers that treat the District as a partner and offer the best overall terms and conditions available. **PRIA is uniquely qualified to accomplish this as we are one of the few agencies that have access to all competitive insurance carriers and programs accessible by agents.**

We also have unique and sole access to a very competitive Excess Workers' Compensation carrier, Colony Insurance. For example, we lowered the Excess Workers' Compensation cost at the City of Tallahassee by $37,643 (20%) in 2014. The incumbent was Midwest Casualty, but Colony provided the same terms at a 20% reduction in rate.

We maintain direct access to all key insurers and use wholesalers only when required or required by insurers. This saves our clients between 5% and 15% in premium on some policies by cutting out a middleman.

A review of prior work history in 4.4.9 will reveal a history of consistent improvement in our client's terms, conditions and costs. Our formula for marketing and negotiating insurance coverage has stood the test of time in both hard and soft market conditions. When we "take over" a risk management program we have never failed to improve the terms and conditions.

4.4.5 Describe the communication strategy by the Respondent. Specifically include a description of the tools or resources available to assist clients in effectively communicating not only the specific plan details but also the value offered.

A. Health

PRIA provides our clients with multiple tools and resources for communicating the provided benefits, value of benefits available as well as multiple other topics such as healthy eating, disease management / prevention, effectively utilizing benefits, etc. We consistently provide in-person meetings, seminars, lunch and learns, newsletters, annual compensation statements, informational fliers and webinars regarding various topics. We provide a Benefits Guide annually to be distributed to each employee and can be used for new hires throughout the year that provides a summary of all available benefit options, cost saving tools and resources, contact information for the PRIA team as well as the carrier partners. **Please see Section 7: Additional Data for a sample Benefit Guide and Employee Communications.** Additionally, if clients and employees have specific questions, issues and/or requests, our team is available by phone and email as well.

B. Property & Casualty and C. Workers' Compensation

Please see our detailed response in 4.3.2. We believe that response succinctly covers our communication strategy.

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4.4.6 Identify the training resources that the Respondent provides to assist clients in educating and training their staff.

A. Health

PRIA regularly coordinates with our carrier partners to provide educational sessions for our clients and their employees. Such sessions include lunch and learns, open enrollment meetings, carrier presentations regarding selected topics, health and wellness fairs, compliance and HR webinars, as well as any requested educational and / or training sessions.

In addition to in-person educational sessions, any of our online technology vendors could include HR portals for employees to complete at time of hire or throughout their employment as required by the District. PRIA also can create custom employee communications regarding a multitude of topics for distribution by intranet, posters, fliers or email to ensure maximum exposure to employees.

B. Property & Casualty and C. Workers' Compensation

We are proficient in training our clients in many areas including but not limited to: Contractual Risk Transfer and Indemnification, FEMA Rules and Procedures, Employment Practices Liability and Florida Public Entity Law.

Below is a listing of the training and educational seminars for audiences of 25 and greater that we have conducted in the recent past. We are willing and able to provide these training opportunities and others that may be relevant to the District's goals.

City of Ocala – July 2019 - 2-hour presentation on Contractual Indemnification and Hold harmless agreements, Procurement Statutes and Rules, Bonds, and Insurance Requirements for Third Parties.

Marion County – July 2019 - 2-hour presentation on Contractual Indemnification and Hold harmless agreements, Procurement Statutes and Rules, Bonds, and Insurance Requirements for Third Parties.

St Johns River Water Management District -November 2018 – 2-hour presentation on Contractual Indemnification and Hold harmless agreements, Procurement Statutes and Rules, Bonds, and Insurance Requirements for Third Parties.

State of Florida – February 2016 – Insurance Focused Disaster Preparedness and Response – 3-hour presentation on preparing for a disaster with a focus on maximizing insurance proceeds and proper policy language.

Employment Practices Liability and Best Practices Seminar (2 to 3 hours) – Conducted at least once in the last 5 years for the following clients: City of Ocala, Marion County, Flagler County, City of Fort Walton Beach, and the City of Haines City.

Harassment in the Workplace 90 minutes – Focuses on preventing and identifying harassment, bullying and discrimination in the workplace. This session is targeted to non-management employees.

In addition, custom education opportunities can be arranged for any training need.

We will also endeavor to make the District aware of any relevant educational and training opportunities available in the State.

4.4.7 Describe Respondent's anticipated involvement in the facilitation or participation in implementation, communication, enrollment and training of District staff.

A. Health

PRIA will be as involved as the District will allow us to be. For the majority of our clients, the assigned PRIA team would facilitate and manage the implementation process of new carriers/vendors. Where open enrollment is concerned, we coordinate with the HR team to strategize on the best approach, such as:

- Are open enrollment meetings prior to open enrollment necessary?
- Will a formal presentation be conducted?
- Will open enrollment meetings be mandatory or passive?
- What materials will be needed and when?
- How will this be communicated to employees?

Communication is critical. PRIA prefers to communicate as much as possible with selected carriers / vendors and our clients. This ensures everyone is on the same page and the processes will typically be much more effective. PRIA commits to communicating however the District deems most effective. Communication between PRIA and the District is typically by phone / conference call, email and in-person. Where employees are concerned, PRIA will, again, communicate in the mode the District deems appropriate. For most of our clients this includes in-person meetings, lunch and learns, newsletters, fliers, emails, if available.

B. Property & Casualty and C. Workers' Compensation

Detailed information on implementation of insurance policies and programs can be found in 4.4.3

Detailed information on communication strategies and process can be found in 4.3.2

Detailed information of our training capabilities can be found in 4.4.6

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4.4.8 Provide evidence of Respondents previous cost control programs, plans or self-funded policies.

A. Health

As part of the Brown & Brown family we can offer a variety of creative cost control solutions that include (may be an additional cost):

- Telehealth Programs
- Wellness Partners
- Mail Order Pharmacy
- Stop Loss Coalitions
- Consortiums
- Captives
- Pharmacy Benefit Manager (PBM) contracts
- Group Purchasing PBM organizations
- Self-funded Underwriting
- Reference Based Pricing contracts
- Value Based Pricing contracts
- Direct Contracting with Providers and Hospitals

More detail of previous and ongoing cost control and/or self-funded plans can be found in our response below to 4.4.9.

B. Property & Casualty and C. Workers' Compensation

Detail of previous and ongoing cost control and/or self-funded plans can be found in our response below to 4.4.9.

As mentioned throughout this response, PRIA is proficient at reducing the cost of risk and balancing the most efficient insurance and self-insurance blend.

A review of work samples below illustrates how we have reduced insurance costs and exposures for clients similar to the District.

Each recommendation for risk transfer or risk retention includes analytical support data as well as future cost projections so that the District can make educated decisions on program design and cost containment programs.

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4.4.9 Provide work samples that demonstrate Respondent's ability to meet and exceed expectations outlined in the Scope of Work.

A. Health

City of St. Cloud – 532 Employees

Employee Benefits Summary – PRIA provides the City with a full complement of employee benefits services. Including servicing and marketing of all employee benefits lines of insurance coverage, health care center, COBRA administration, quarterly/ semi-annual claims review, open enrollment meetings, health fair, benefits-at-a-glance booklets, OPEB Filing, Actuarial Services, Online Enrollment system, Telehealth Program, Employee Assistance Program, Mail Order Pharmacy Program, compliance updates and ACA Reporting.

PRIA was awarded the City of St. Cloud's agent of record contract in April 2011. Since that time, we have saved the City more than **$6,000,000 in premium** when compared to the fully insured program that was in place in 2011. At the inception of our agreement the City was fully insured, did not have a wellness program, and continued to struggle with double digit premium increases on their medical plan. Through a carefully constructed and innovative plan we mapped out a strategic vision to improve the cost effectiveness of the City's short and long-term healthcare benefits program.

2014 / 2015 Plan Year

Our objective for 2014 was to increase employee utilization to the health care center, monitor the disease management program through Marathon Health due to ongoing large claims and continued rise of health insurance cost. After our continued evaluation of the City's current plan utilization and cost control, we worked with staff to provide:

- Health Care Center employee participation rose to 70% due to promotion, plan design and education aimed directly to employees
- Cost savings plan design changes with the least amount of impact to the employees and their families. PRIA implemented these changes after a detailed utilization process thereby minimizing the impact on employees
- Examined 4 pharmacy benefit vendor programs for cost containment and specialty drug programs

2015 / 2016 Plan Year

Our objective for 2015 was to see continued high level utilization of the employee health care center as well as continued engagement in the wellness initiatives.

- Presented a plan design analysis showing the best plan options for the City's self-funded program to further incentivize employee utilization to the health care center.
- The City has experienced the true strength and savings from a self-funded health insurance program and an onsite health care center. The City had endured multiple large claimants for two consecutive years driving up claim cost. However, as a result of transitioning to a self-funded plan and implementing the Health Care Center, we were able to sustain an

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enhanced employee benefit program while still controlling costs. The total 2-year cost (2013 to 2015) of the self-funded program and the Health Care Center was $ 7.9 million, while a fully insured insurance program alone would have cost over $10 million dollars.

2016 / 2017 Plan Year Renewal

Our objective for 2016 was again to increase utilization of the employee health care center as well as continued engagement in the wellness initiatives. We also aimed to save the City money through the renewal RFP process. Through carrier negotiations and actuarial expertise, PRIA saved the City $75,312 in Stop Loss premium, $22,018 on Dental, for a total of ***$97,330***.

- Benchmarking is a tool we routinely use to determine the level of cost efficiency and competitiveness of our benefits program designs. For example, a benchmarking comparison of the City of St. Cloud's and the City of Kissimmee's programs done in 2016 reveals that the City of St. Cloud's health insurance cost per employee was about 20% less than Kissimmee's cost. Even more revealing is that St Cloud's benefits program is a traditional PPO while Kissimmee's is a high deductible plan.
- The City's cost per employee per month for the Health Care Center was also about 15% less than Kissimmee's cost ($62.16 vs $72.77). *This comparison is based on data received directly from Kissimmee in July 2016.
- Health Care Center employee participation rose to 75% due to promotion, plan design and education aimed directly to employees.

2017 / 2018 Plan Year Renewal

Our objective for 2017 was to continue to drive results and engagement at the clinic and further promote a culture of health and wellness at the City.

- Onsite Health Care Center (Healthy4Life) – PRIA negotiated the increased hours and renewal pricing.
- Administrative Services Agreement with Florida Blue – PRIA negotiated the contract extension with no fee increase and an additional ***$100,000*** in wellness dollars through October 1, 2019.
- Stop Loss – through PRIA's analysis on the City's stop loss retention level and history of large claimants we were able to reduce the City's renewal increase from 6% to a 5%, an annual savings of ***$110,783***.
- Dental Insurance – After examination of the City's 2-year claim history with MetLife, PRIA negotiated a 9% annual increase down to a 4% increase, an annual saving of ***$17,000***.
- Savings Achieved:

Administrative Services Agreement Wellness	$100,000
Stop Loss Renewal	$110,783
Dental	$ 17,000
Total Renewal Savings for 2017/2018	**$227,783**

2018 / 2019 Plan Year

Our objective for 2018 was again to see high level utilization of the employee health care center and to promote meaningful wellness initiatives, while assisting the City with the Onsite Clinic RFP. As with each year, we strived to save the City money through the renewal RFP process.

- Through our negotiations with the carriers and expertise of our actuary, PRIA saved the City $35,510 in Stop Loss premium, $19,238 on Dental, for a total of ***$54,748***. *We also negotiated another $25,000 wellness fund from Florida Blue.*

Throughout the year. We worked with staff to provide the following:

- Increased biometric screening rate to 88% of all employees, with 93% of those with chronic conditions engaged with the health center.
- Assisted HR and purchasing with developing RFP specifications for the onsite clinic RFP
- Assisted procurement with answering vendors questions throughout the RFP process.
- Once CareHere was selected, PRIA began working with Marathon Health, CareHere and the City to ensure a smooth transition with minimal impact to the employees.
- Reviewed in depth claims analysis provided by our Senior Analytic Consultant.
- Provided benchmarking, funding projections, budget recommendations based on PRIA's actuary's recommendation to allow for plenty of time for budget.
- Conducted multiple Employee Lunch and Learns at the health care center.
- Assisted with Lakefront Walking Challenge, which engaged 55% more of those employees that were not already engaged at the health center.
- Provided actuarial certification for the City's annual State Filing for their self-funded health insurance plan.
- Affordable Care Act Employer Responsibilities – PRIA provided the following guidance:
    - Patient Center Outcome Research Institute – payment and filing IRS form 720.
    - Transitional Reinsurance Filing - TRF Reporting and filing assistance.
    - Health Plan Identification (HPID) – Filing to Centers from Medicare and Medicaid Services.

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City of Sarasota – 658 Employees & 523 Retirees

Employee Benefits Summary – PRIA was awarded the City of Sarasota's Employee Benefits consulting contract in December 2016. Included in this contract is the complete suite of employee benefits brokerage, consulting, and support services. Including complete marketing of employee benefits coverages, onsite health care center, quarterly claims reviews, open enrollment meetings, health fair coordination, benefits-at-a-glance booklets, OPEB Filing, Actuarial Services, Online Enrollment system, Telehealth Program, Employee Assistance Program, Mail Order Pharmacy Program, and compliance updates.

Over the years we have worked with the City to ensure they are making the most out of their onsite health center and using the health center to drive costs down on their health plan. Each year, PRIA works with the City to develop any RFPs according to when each contract is expiring.

In 2019, PRIA worked with the City to develop RFPs for medical, Rx, dental, vision, stop loss, HRA, FSA, COBRA, and Online Enrollment. During pre-renewal discussions, PRIA recommended the City evaluate carving out their prescription drug plan for the 2020 renewal due to the substantial savings we have seen for other clients recently through a **Group Purchasing Organization** we have access to. After the RFP process, PRIA's Senior Analytic Consultant analyzed and repriced all medications through the various respondents. The result was astounding. The City is projected to **save over 36%** on their prescription drug costs in 2020, resulting in over **$1.3 million in savings**. This was due to improved purchasing terms and stronger rebates.

For medical, PRIA worked for months in assisting the City with evaluating ASO options. This included finalists' interviews, **repricing analysis on claims** to determine the strength of each carrier's network and a **disruption analysis on networks** to ensure employees would not be negatively impacted by a change in carrier/network. The City's final ASO contract resulted in over **$450,000 in wellness funds** and substantial improvements to the benefits communication tools available to the employees.

B. Property & Casualty and C. Workers' Compensation

PRIA is dedicated to the Public Entity insurance sector. Our experience with large public entities is extensive. We manage large property and casualty and excess workers' compensation insurance programs for over 35 public entities in Florida. As a company (including all Brown & Brown offices) we place more property coverage in the excess and surplus lines marketplace than any other broker in Florida. PRIA alone places and manages multi-layered public entity property insurance programs for over **$36 billion** in total insured values. Our entire organization handles hundreds of similar programs nationwide. Hands on experience and the results of that experience speak volumes for an insurance firm. **Evidence of our abilities and experience with Florida's governmental entities is not solely in a statement trumpeting our greatness but in our recent past performance on behalf of the District and other public entities.**

City of St. Cloud – $122M in Property TIV

PRIA has managed the City's property and liability insurance program since 1997. We were awarded the City Broker of Record for Workers' Compensation insurance in 2011. Our focus has always been on reducing the City's Total Cost of Risk and not simply selling and binding insurance. Our process and methodology have proven to be consistently beneficial to the City over many years. To illustrate the superiority of our service approach and discipline we submit this short summary of examples of cost savings and improvements we have achieved on behalf of the City.

- Analyzed deductibles and self-insured retentions every year with cost benefit analysis reports submitted to the City as part of every insurance renewal. Some Examples include:
  - 2004 – Evaluated the City's physical damage deductibles resulting in a deductible change that saved the City **$8,362** per year.
  - 2005 – Evaluated and amended the Inland Marine insurance deductible and saved the City **$4,511**.
  - 2006 – Evaluated all retentions and deductibles for cost efficiency. Resulted in several program changes and **$17,829** in premium reductions.
  - 2012 – Evaluated all retentions and deductibles for cost efficiency. Resulted in more program refinement and **$38,912** in premium savings.
  - 2013 – Negotiated a **$64,739** premium reduction on the property and liability renewal. Original quote was $892,592 and PRIA negotiated a final premium of $827,853.
  - 2015 –
    - Provided a Total Cost of Risk Analysis comparing St. Cloud, Kissimmee, Osceola County and Osceola School Board. Conclusion was that St. Cloud's cost of risk for liability is in line with Kissimmee and the County, however St. Cloud's workers' compensation cost is much higher than the other entities.
    - Negotiated a **$133,420** premium savings on the City's workers' compensation insurance.
  - 2016 – Analyzed the potential for savings in establishing a self-insured workers' compensation program.

- **The Self-Insured Workers' Compensation program was implemented in March 2017. Annual savings to date:**
    - $314,000 in fiscal year 16/17
    - $430,000 in fiscal year 17/18
    - $550,000 in fiscal year 18/19
- Safety Committee Program – PRIA started the City's program in early 2013. As a result of our efforts (and City Staff's) the current average monthly workers' compensation losses have been reduced to $10,000 per month compared with $63,000 a month in 2013. PRIA will continue to participate in each Committee meeting contributing meaningful accident causation analysis and corrective action recommendations.
- PRIA has assisted with drafting new insurance requirements for vendors and contractors by providing full drafts of industry accepted specifications as well as examples of specifications from other Florida cities.

City of Sarasota – $300M in Property TIV

PRIA has managed all the property and casualty insurance and risk management needs of the City since 2009. In 2009 and 2016 the City conducted a Statewide Request for Qualifications and chose PRIA as the most qualified agent. Below is a summary of our some of our accomplishments and ongoing services.

- Provided $450,000 in premium savings in the first year PRIA managed the placement of insurance policies.
- Designed a comprehensive insurance and self-insured program including custom policy language with various self-insured retentions. This design is evaluated and adjusted on an annual basis.
- Provided savings and reductions in total cost of risk nearly every year for 9 years!
- Provide professional consultation for indemnification agreements and risk transfers.
- Managed large claim settlement negotiations and maximized claim proceeds on behalf the City.
- Negotiated with incumbent workers' compensation carrier to maintain the City's preferred $500k SIR despite a hardening market in 2013.
- Managed numerous competitive informal bid processes for the City's property and casualty insurances resulting is consistent savings and re-alignment with competitive insurers. Benchmarking in 2019 revealed that the City's property renewals have outperformed neighboring entities such as Clearwater, St. Petersburg and Manatee County in rate decreases and overall terms.
- Conduct quarterly claims reviews to address loss trends with corrective action recommendations.
- Provided Cyber training and best practices protocols.

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Brevard County – $800M in Property TIV

PRIA was awarded as the County's Agent of Record in a statewide Request for Qualifications process in March 2014 and again in 2019. The former agent was **Arthur J. Gallagher**. PRIA manages all property, casualty and workers' compensation insurance programs. In five years, we have accomplished the following:

- In the first property insurance renewal (2014), PRIA reduced the overall property premium by $282,948 through negotiating and realigning carriers. **This was a 15% rate reduction.**
- Reduced the number of carriers on the program from 9 to 5.
- Greatly improved the property coverage terms by:
    - Upgraded loss valuation from Margin Clause to Blanket coverage
    - Fixed the property schedule to remove erroneous values for contents that the previous agent added to the property schedule
    - Improved the Inland Marine policy by eliminating the audit requirement thereby saving the County significant premium
    - Reduced the High and Low Hazard flood deductible
    - Increased several coverage sublimits
    - Provided a Claims Preparation Expense limit of $100,000 (zero prior)
- Conducted a thorough Flood Audit and placed flood coverage for 19 properties.
- The 2015 Property renewal resulted in another reduction of 10%.
- The 2016 Property renewal provided another reduction of 6%
- The current property rate of 21.9 cents is 13% less than rate in 2013 (2013 was the last year before PRIA handled the County's insurance).
- **Total savings to the County in five years is well over $500,000.**
- PRIA worked closely with FEMA coordinators, claims adjusters and insurers to maximize hurricane claim proceeds. The County has suffered significant losses after Hurricanes Matthew and Irma and PRIA has been directly involved in all recovery efforts.

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Citrus County – $286M in Property TIV

PRIA was awarded as the County's Agent of Record in a statewide Request for Qualifications process in March 2014 and again in 2005. The former agent was **Arthur J. Gallagher**. PRIA manages all property, casualty and workers' compensation insurance programs. In the recent past we have accomplished the following:

- In the first property insurance renewal (2005), PRIA reduced the overall property premium by $644,000 through negotiating and realigning carriers. **This was a 15% rate reduction.**
- Negotiated manuscript coverage with the property carrier giving the County coverage for County-wide debris removal (not just county property) when required by local authority
- Placed property insurance coverage for all utility structures with a utility insurance specialty carrier resulting in greatly reduced cost, much better coverage and provided loss control/engineer's surveys
- PRIA improved the insurance requirements for contractors and the process of contractual risk transfer with contractors and vendors. PRIA provided guidance and assistance in drafting new procedures and requirements. We also conducted a workshop for local vendors and contractors in order to educate the companies doing business with the County.
- Conducted many educational workshops and seminars specific to contractual indemnification, labor law, defensive and safe driving, heavy equipment operation, etc.
- Evaluated the disaster recovery plan with utilities department (twice) to ensure proper insurance limits were in place and plans were adequate.
- The current property rate of 29 cents is 40% less than rate in 2009.

As testament to our ability to successfully manage complex public entity insurance programs we offer the following list of clients for whom we manage BOTH the Employee Benefits AND the Property & Casualty / Workers' Compensation programs:

Municipalities

Cities of Sarasota, St. Cloud, Haines City, Groveland, Davenport, Chipley, Edgewater, Port Orange, Ormond Beach, and Miami Gardens

Counties

Counties of Madison, Wakulla, and Jefferson

Special Districts

Collier Mosquito Control District

4.4.10 Describe how Respondent's organization strives to streamline services for your clients. Include any services you provide for automation of the process (i.e., electronic capabilities, outsourcing options). Attach any associated costs for these services on a separate fee schedule.

A. Health

PRIA strives to stay at the forefront of technology platforms as well as any other services or products that we feel will provide additional value to our clients and their employees. Brown & Brown has invested significant resources in our EB Tech team that are consistently vetting new and innovative technology solutions to assist our clients with their online enrollment needs. The cost for the online enrollment platform may vary depending on the selected vendor. **Technology platforms typically are between $2.50 - $5.00 per employee per month. We will also request subsidies from the District's selected carrier partners to absorb a portion of the cost.**

PRIA has been able to offer a more robust wellness program to our clients and their employees through third party wellness vendors. Again, the cost would vary depending on the selected vendor, extent of program desired and additional services selected. We would include a request for a wellness budget to assist in covering a portion of the vendor cost during a procurement process as well.

For both a wellness vendor and an online technology platform, PRIA would assist the District in managing a procurement process to ensure the chosen vendor has the ability to provide the most beneficial solutions at the best cost.

B. Property & Casualty and C. Workers' Compensation

PRIA assists in the completion of all insurance applications. We proactively assemble underwriting data from accessible sources such as annual financial reports, District website, District capital asset management lists, loss reports, budgets and other similar reports. We perform these functions to reduce and streamline your administrative burden.

A standard PRIA practice for the workers' compensation renewal is to audit the District's SI-5 reports to determine the accuracy of future payroll estimates. Payroll estimates are the basis for premium, so accuracy is imperative. Many excess workers' compensation policies will only return a maximum of 10% of the written premium after an audit.

In Section 7, Additional Information, you will find data on an automated web-based asset management platform (AMP) that could greatly streamline the District's asset management function. This resource is provided at no cost to the District. A trial period and demonstration of this tool can be arranged to determine the value to the District.

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4.4.11 Describe how Respondent's firm provides continuing education to ensure that each broker is educated on current market trends and legislative developments? How is this information communicated to your clients?

(This information is proprietary and confidential and is not subject to public record)

BBU Introduction

Teammate development is very important at Brown & Brown. Our company leaders believe that change is constant, but culture survives, so Brown & Brown is forever. We want to constantly and consistently get better. Growth, change and teammate development is the hallmark of a healthy, flourishing company.

Brown & Brown University is a critical part of our ongoing education program and a key component of our relentless pursuit of talent development. At BBU, teammates, mentors, and leaders gain knowledge and form bonds that are the building blocks of a strong team. This helps drive our advocacy and service model, supports cross-company collaboration, and ultimately furthers our success.

Structure of BBU

Brown & Brown University is designed to ensure that new and existing teammates receive consistent messaging regarding company culture, compliance, and job-related processes and procedures. Due to the decentralized nature of Brown & Brown, some profit centers may have extensive education programs in place, while others do not. The learning products available within Brown & Brown University may either replace or supplement the existing profit center education program.

New Brown & Brown teammates are automatically enrolled in the Onboarding curriculum. They have 30 days to complete the training and upon completion are automatically enrolled in the school and curriculum that best matches their role in the company. Existing teammates are automatically enrolled in the appropriate school and curriculum as it is deployed in the learning management system or as their role within the company changes.

Proprietary and Confidential

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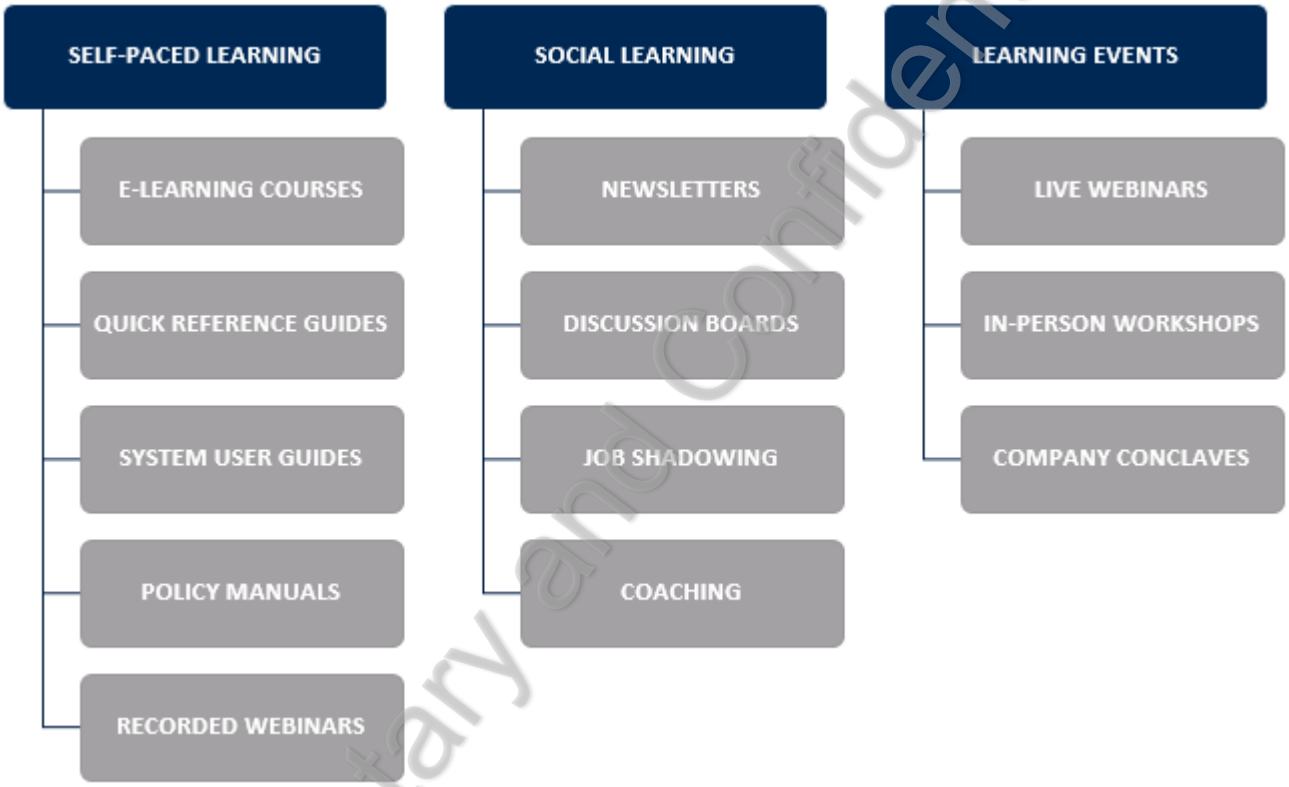
(This information is proprietary and confidential and is not subject to public record)

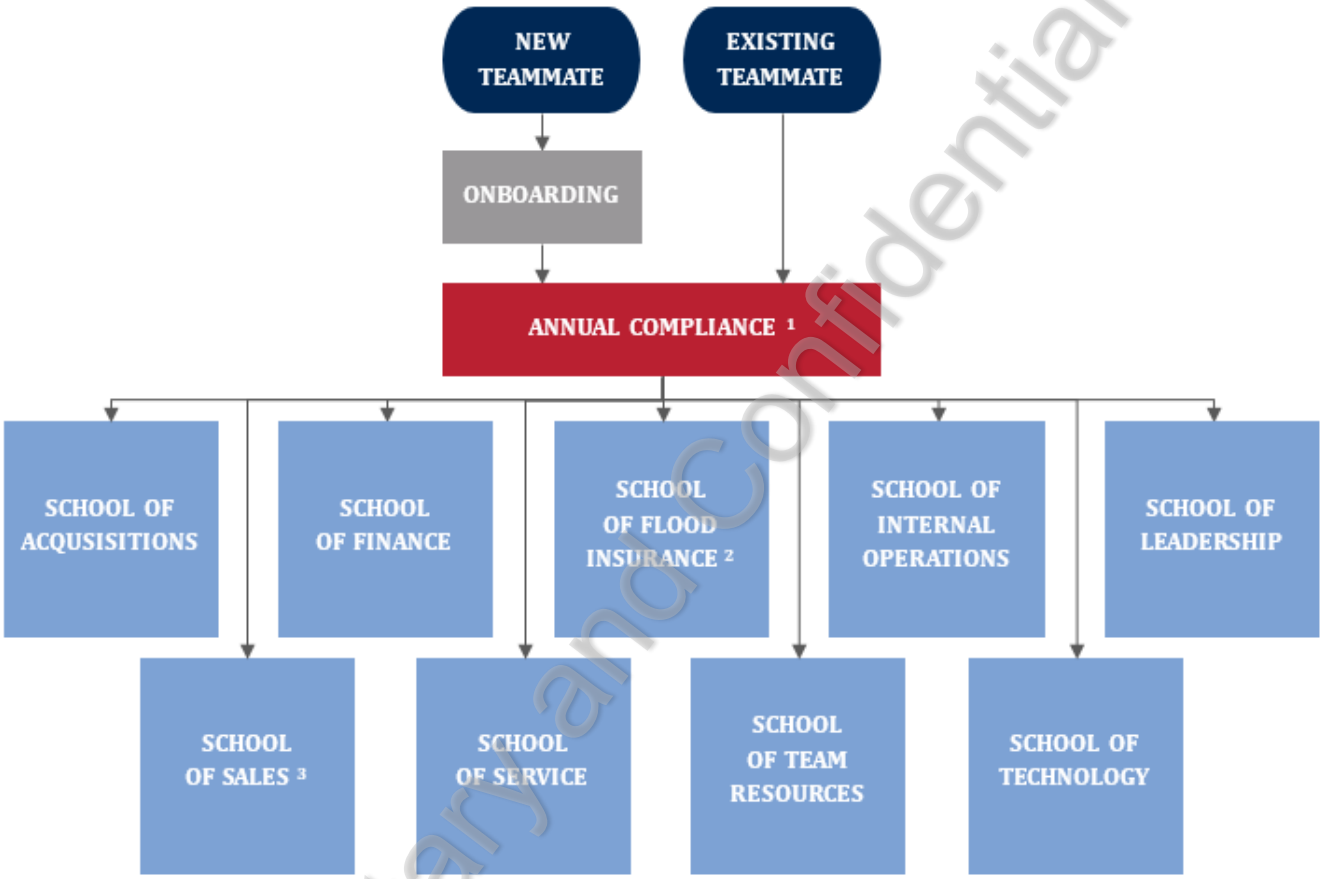
In addition to a teammate's job role training, which is automatically assigned, all learning products within Brown & Brown University are available to all teammates. The catalog within the learning management system allows teammates to browse or search for any items of interest. Learning products include:



Proprietary and Confidential

(This information is proprietary and confidential and is not subject to public record)

The basic structure of Brown & Brown University is as follows:



In addition, each staff member is State licensed and has earned at least one of the following advanced insurance credentials;

- ARM – Associates in Risk Management
- RMPE – Completion of Risk Management for Public Entities course
- CIC – Certified Insurance Counselor
- CISR – Certified Insurance Service Representative
- CRM – Certified Risk Manager
- CSRM – Certified School Risk Manager

Proprietary and Confidential

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4.5 CUSTOMER SERVICE / CLAIMS RESOLUTION.

4.5.1 Identify the structure of the customer service team that will be assigned to the District, including:

4.5.1.1 Location of Respondent office(s) at which customer service representatives are located.

220 S. Ridgewood Avenue, Suite 210
Daytona Beach, FL 32114

4.5.1.2 Number of employees located in Respondent's customer service office(s).

PRIA currently has 22 employees located in our Daytona Beach office.

4.5.1.3 Hours of operation for Respondent's customer service office.

Our hours of operation are from 8:00 AM to 5:00 PM.

4.5.1.4 Customer service toll free number.

(800) 877-2769

4.5.1.5 Commitment that customer service representatives will be present at District offices when requested by the District as required by this ITN.

PRIA commits to having a representative present at District offices when requested by the District as required by this ITN. We are accustomed to frequent travel in Florida and have no problem traveling to any of the District's locations.

4.5.2 Describe the typical group load of a customer service representative, including the following:

4.5.2.1 Total number of clients.

Each of our customer service reps handles on average 10- 15 clients. (We do handle a large book of small CDD / Special district clients. These are handled by one customer service rep who handles dozens of accounts due to their extremely low-service needs nature)

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4.5.2.2 Total number of lives and/or assets administered and/or insured.

Total Number of lives administered by PRIA – 6,400
Total assets administered / insured by PRIA by Total Insured Value - $43 Billion

4.5.2.3 Maximum number of lives for which a customer service representative is responsible.

We do not set an internal maximum on lives for which our CSR's are responsible. Workload is determined by client needs, which vary widely by account. These workloads are monitored annually during our annual service review – during which we utilize client feedback, satisfaction surveys, and CSR and Account Executive input on workloads to adjust the entire PRIA book of business for best in class results. As of this moment, the maximum amount of lives covered by any one CSR is 1,800.

4.5.3 Describe Respondent's customer service problem or issue resolution process. (Maximum of two (2) pages)

A. Health

The PRIA executive account management team assigned to the District manages the daily service issues that may arise regarding claims, compliance, billing and eligibility. Due to our status with the insurance carriers, we have the distinct advantage of having a dedicated contact in each carrier's home office to assist us with resolving any issues in the most efficient manner possible***.*** ***It is our goal to resolve all issues within a 24-hour period.*** If we cannot meet that deadline, we will contact the District's team with an update stating why we are unable to resolve the issue and include an expected time frame for resolution. The assigned Employee Benefit Advisor, Melanie Stegall, will provide both direct office and cell phone numbers and email address that may be used at any time including nights, weekends and holidays. The assigned Employee Benefit Specialist (or backup, if necessary) will be available by direct office phone number or email during business hours.

B. Property & Casualty and C. Workers' Compensation

It is our goal to resolve all issues within a 24-hour period. If we cannot meet that deadline, we will contact the District's team with an update stating why we are unable to resolve the issue and include an expected time frame for resolution. The assigned Team Leader will provide both direct office and cell phone numbers and email address that may be used at any time including nights, weekends and holidays. The assigned Claim Specialist and Service Representative (or backup, if necessary) will be available by direct office phone number or email during business hours.

For large claim resolution we will attend and facilitate in-person claim reviews.

For catastrophic losses we typically meet with insurance adjusters, FEMA representatives, FEMA consultants and contractors to expedite the entire recovery process.

Our record of resolving insurance related issues is exemplary. We would not be able to retain 97% of our clients if we were not proactive in the dogged pursuit of dispute resolution.

We will always represent our client's interests first and the interests of the insurers second!

4.5.4 Describe Respondent's ongoing claims questions or problems support to be provided to the District.

A. Health

PRIA's assigned team is committed to exceptional claims advocacy and providing meaningful claims assistance to our clients. We routinely engage with our carrier partners on behalf of our clients to expedite the successful resolution of claims issues. PRIA has extensive experience assisting our clients with claims, both large and small. Our position is that we work for and represent our clients and their employees, not the insurance carriers. As a claims advocate, we will communicate with both the employee and the District to ensure everyone is on the same page. We are also willing and able to coordinate and attend claims meetings to ensure the necessary parties are aware of any outstanding claims issues, high cost claims and overall state of the District's claims, as it related to the District's health insurance coverage.

B. Property & Casualty and C. Workers' Compensation

PRIA is committed to exceptional claims advocacy and providing meaningful claims assistance. We are routinely engaged with carriers on behalf our clients to expedite the successful finalization of open claims. We are also not shy about acting as a claims advocate for our clients. We have successfully negotiated favorable claims settlement terms with the District's liability insurers on many occasions.

PRIA has extensive experience assisting our clients with claims both large and small. Our position is that we work for and represent our clients and not the insurance carriers. The District will never question which side of the fence we are on. As a claim advocate, we will work closely with you and directly on your behalf with insurance carriers. We are willing and able to coordinate and attend claims meetings in an effort to resolve claims quickly and equitably. We have a staff member whose primary function is to ensure that all claims submitted through our office are received and acknowledged by an adjuster within 24 hours. We also follow up with adjusters on large open claims to ensure claims handling is in step with the client's desires.

The District's Team Leader, Paul Dawson, has managed many very large catastrophic property claims (10 Major Hurricanes), many high-profile liability claims and many contentious workers' compensation claims. Experience and institutional knowledge gained from managing these claims for public entity clients has proven invaluable in achieving the most favorable outcomes for our clients.

4.5.5 Identify the Respondent's home webpage address.

4.5.6 Identify the Respondent's web-based customer service website address (if different from the home webpage address).

www.bbpria.com

4.5.7 Describe Respondent's protocols to assure the security of customer service website. (Maximum of two (2) pages)

PRIA does not own or provide a customer service website. Our customer service is performed one-on-one with our clients in person, over the phone and via email. All PRIA email and data servers are protected by SOX compliant data and transmission systems.

4.5.8 Describe the ongoing administration (i.e. billing and enrollment) Respondent will provide to the District.

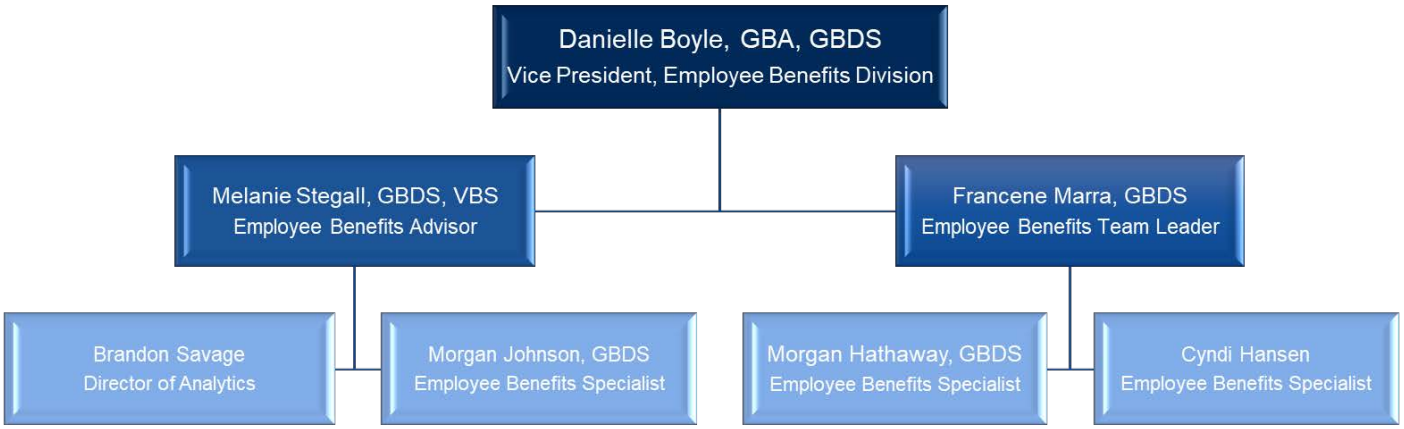
A. Health

PRIA's dedicated service team consistently assists our clients with ongoing billing, claims issues and resolution and enrollment assistance. Many of our clients grant our team broker access to carrier portals and online benefit technology platforms to assist with new hire enrollments, terminations, billing, etc. Our team will also provide District staff and employee educational meetings necessary to ensure understanding of any new lines of coverage, carrier, service or product.

4.6 IMPLEMENTATION TEAM QUALIFICATIONS.

4.6.1 Provide an implementation team organization chart identifying the structure of the team and identifying the key personnel that will implement the Respondent's services (Implementation Team Members). The Implementation Team must include an Account Executive and all Implementation Team Members must be employees of the Respondent. (Maximum of one (1) page)

A. Health



B. Property & Casualty and C. Workers' Compensation

We believe this section is specific to Health Benefits. There is no implementation process for property, casualty and workers' compensation policies.

4.6.2 Provide the resumes for each Implementation Team Member who will assist in the integration of services with District staff and systems, detailing their role on the team and their qualifications to provide services to the District including the following as applicable: (Maximum of two (2) pages per team member)

All resumes are directly following this page.

Danielle Boyle, GBA, GBDS
Vice President, Employee Benefits Specialist

EXPERIENCE

Public Risk Insurance Advisors/ Brown & Brown of Florida, Inc.
Daytona Beach, FL
2009 - Present – Vice President, Employee Benefits Specialist
Senior consultant responsible for a book of business made of complex public entity and large private sector clients. Responsibilities include, but are not limited to renewal negotiations, RFP development and analysis, contract review, claims analysis and budget recommendations, presentations to leadership and elected officials, compliance review, wellness program design and implementation, and project management for ongoing services for each client.

EDUCATION

Bachelor of Business Administration, University of Central Florida

LICENSES AND CERTIFICATIONS

2-15 Life, Health & Variable Annuities, State of Florida
Group Benefits Advisor (GBA)
Group Benefits Disability Specialist (GBDS)

SERVICES AND ACTIVITIES

Volusia League of Cities
Florida School Boards Association
Florida Association of Special Districts
Central Florida Association of Legal Administrators

Melanie Stegall, GBDS, VBS
Employee Benefits Advisor

EXPERIENCE

Public Risk Insurance Advisors
November 2015 to present. Employee Benefits Advisor
Responsibilities include direct consulting with clients to identify, analyze, develop and design employee benefit programs for Florida Governments and Special Districts. Professional client services include claim reports, benchmarking, compliance updates, Affordable Care Act employer compliance and employee education, marketing benefits, insurance carrier negotiations and contract review. Effective and efficient communication methods for elected board presentations, committee meeting participation, and union negotiations.

PNC Bank
June 2006 – November 2015 Branch Manager
Responsibilities include small business development including, but not limited to, consulting with clients on their business's financial standing, analyzing current accounts and financial programs currently being used and recommending enhancements or opportunities to save on cost and increase cash flow. Managed a team of 7 to work as a team to work efficiently and effectively meet and exceed branch goals as well as client expectations.

EDUCATION

Kansas State University, BS Degree, Business Administration
Group Benefits Disability Specialist (GBDS)
Voluntary Benefits Specialist (VBS)

LICENSES

2-15 Life, Health & Variable Annuity License, State of Florida

PROFESSIONAL AFFILIATIONS

VLOC-Volusia League of Cities
RLOC-Ridge League of Cities
Tampa PRIMA
FASD-Florida Association of Special Districts

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Francene Marra, GBA, GBDS
Employee Benefits Service Team Leader

EXPERIENCE

Public Risk Insurance Advisors
August 2017 – Present. Employee Benefits Service Team Leader
Responsible for leading the team of employee benefits account representatives to ensure that all clients have a high-quality customer service experience. Responsibilities include serving as a primary point of contact for all service requirements, working closely with clients to form effective business relationships through proactive client service and manage renewals efforts. Analyze carrier reports, benefit plan structures, plan design and industry trends and makes appropriate benefit plan recommendations. Act as liaison between clients and the Insurance Carriers to resolve escalated complex service issues that require policy interpretation. Ensure all Quality Control requirements are met.

January 2013 – July 2017. Account Representative
Responsibilities included working with public entity benefit clients. This includes the day to day servicing of benefits accounts, settling and tracking claims, settling any billing disputes, corresponding with human resources and directly with employees, marketing to obtain the best product and pricing for the clients. Facilitate open enrollment meetings and wellness programs / health fairs for our clients. Provide technical support to the Account Executives.

Duvasawko ED Billing and Management Solutions
May 2008 – January 2013. Medical Billing Representative
Electronic billing for emergency room doctors and hyperbaric wound care doctors. Post payments. Research and resolve account disputes. Insurance appeals. Work aging report. Retrieve and create Electronic Remittance Advice (ERA). Data entry, including deposits, patient and insurance demographics, denials, and memos regarding claim follow up. Process incoming and outgoing phone calls. Customer support. Utilize the following: Microsoft Word, Excel, and Outlook.

EDUCATION

Daytona State College, Daytona Beach FL
Keiser University, Daytona Beach, FL
Group Benefits Advisor (GBA)
Group Benefits Disability Specialist (GBDS)

LICENSES

2-15 Life & Health, Including Variable Annuities, State of Florida

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Morgan Johnson
Employee Benefits Marketing Analyst

EXPERIENCE

Public Risk Insurance Advisors
December 2018 to Present. Marketing Analyst
Advanced knowledge of health insurance markets, products and identifying qualified products and appropriate carrier opportunities to improve benefits programs and manage costs. Responsible for initiating all marketing services and approach all markets as appropriate on behalf of all clients and prospects. A full market search is conducted for all lines of insurance currently in place for a client as well as any new lines of coverage requested or required due to risk exposures. Track carrier financial status and communicate to the Department so that clients are notified in advance of any negative change in status.

January 2017 – December 2018. Account Representative
Responsibilities include working with public entity benefit clients. This includes the day to day servicing of benefits accounts, settling and tracking claims, settling any billing disputes, corresponding with human resources and directly with employees, marketing to obtain the best product and pricing for the clients. Facilitate open enrollment meetings and wellness programs / health fairs for our clients. Provide technical support to the Account Executives.

Publix Super Markets, Inc.
February 2011 – October 2016. Customer Service Staff
Responsibilities included, but not limited to, training new Customer Service Staff, Front Service Clerks, and Cashiers. This includes training new Customer Service Staff on all cash office operations including opening tasks, closing tasks, deposits, etc. Successfully handling customer complaints and resolving issues accordingly. Being an active member of Safety/Accident Prevention Team. Daily supervision of Cashiers and Front Service Clerks. Required strong problem-solving skills and associate relations, as well as expert knowledge in providing answers for complicated operational questions.

EDUCATION

Daytona State College, Daytona Beach FL

LICENSES

2-15 Life & Health, Including Variable Annuities, State of Florida

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Brandon Savage
Director of Risk Management

EXPERIENCE

Brown & Brown of Florida, Inc. Daytona Beach, FL
2016-Present – ***Director of Risk Management - Risk Department***
Responsible to evaluate financial and plan design performance for self-funded and large experience rated benefit plans for clients with 750+ eligible private sector employees, and public sector clients. Responsibilities also include assisting with evaluation of marketing proposals, including fully-insured and partially self-insured, pharmacy benefit management, and additional projects. Maintain communication with account executives and managers of any potential service issues as revealed via claims analysis

Corporate Synergies Orlando, FL
2014-2016 – ***Director of Account Management***
Primary resource for overall service schedule and client satisfaction. Leadership role in creation and rollout of departmental policies and procedures, carrier partnerships. Created due diligence checklist/data request for new clients and prospects to ensure onboarding was successful, timely and efficient. Resource for strategic management of complex fully-insured and most self-funded groups.

Bouchard Insurance Orlando, FL
2012-2014 – ***Account Executive, Analyst, Account Manager***
Primary as the primary service contact for public sector and private sector clients. Responsible for client strategy development and execution, day-to-day service. Leadership role in creation and rollout of departmental policies and procedures, carrier partnerships. Resource for strategic management of complex fully-insured and most self-funded groups.

Mercer Orlando & Tampa, FL
2008-2012 – ***Analyst***
Responsible for the marketing process, network and financial analysis & renewal, and implementation management. Overall management of monthly plan performance updates, including overall plan performance, stop loss, dental, and vision updates

EDUCATION

Bachelor of Science in Business Administration, State University of New York at Brockport

LICENSES

2-15 Life, Health & Variable Annuities, State of Florida

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Paul Dawson, ARM-P
Senior Vice President / Public Risk Advisor

EXPERIENCE

Public Risk Insurance Advisors
1995 to Present. Senior Vice President / Public Risk Advisor
Responsibilities include direct consulting with clients to identify and analyze risk exposures and coverage needs and develop and design individualized insurance programs. Professional client services include oversight of insurance and risk management programs, including claims advocacy, internal policy and procedures development, and contract review. Effective and efficient communication methods for elected board presentations, committee meeting participation, and coordination of daily staff service objectives.

E.I. DuPont
1987 to 1995
Safety Manager, Southeast District
Large Account Representative.
Responsibilities including implementation of ISO 9000 programs, new product marketing plans, fleet safety and new employee training.

EDUCATION

Associates in Risk Management (ARM)
Risk Management for Public Entities (RMPE)
Valencia Community College

LICENSES

2-20 General Lines Agents License, State of Florida

PROFESSIONAL AFFILIATIONS

FAC – Florida Association of Counties
FLOC – Florida League of Cities
FERMA – Florida Educational Risk Management Association
FSBA – Florida School Board Association
PRIMA - Public Risk Insurance Management Association, Associate Member & Speaker

AREAS OF SPECIAL EXPERTISE

Florida Public Entity Large Property Insurance Programs
Alternative Risk Financing and Implementation
FEMA Regulations
Contractual Indemnification and Risk Transfer
Catastrophic Modeling (AIR & RMS)
Florida Public Entity Law

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Robin L. Russell, CISR, CSRM
Director of Operations

EXPERIENCE

Public Risk Insurance Advisors
April 2010 to Present. Director of Operations
Oversee day-to-day operations for support staff and operational issues. Supervisor of the Specialist Team, provide support for AMS procedures and training. Monitor processing procedures and maintain quality control standards for the office. Direct and support agency operational needs. Service of select accounts.

July 2004 to April 2010. Customer Service Representative
Responsibilities include working with mid-sized to large public entity clients. Handle requests for certificates of insurance, policy changes and endorsements, claims issues, and other daily servicing duties. Manage initial notices of claims. Track claims activity until adjustors close files. Help address conflicts that may arise from claimants, insureds, and carriers. Provide technical and clerical support for public entity service representatives.

State Farm Insurance
August 1998 to June 2004. Insurance Account Representative
Performed a range of insurance and financial sales and customer service functions. Handled the receiving, filing, and tracking the status of claims to facilitate appropriate resolutions, build customer satisfaction, expand account relationships. Clarified complex insurance terminology and procedures to educate customers. Responsible for incoming money and processed daily deposits. Trained and assisted all team members with day-to-day activities.

EDUCATION

Florida State University, BS Degree, Risk Management/Ins. and Finance
Certified Insurance Service Representative (CISR)
Certified School Risk Management (CSRM)
Risk Management for Public Entities (RMPE)
FEMA Public Assistance Program
Candidate for Associate in Risk Management (ARM)

LICENSES

2-20 General Lines Agents License, State of Florida
2-15 Life, Health, and Variable Annuities License, State of Florida
1-20 Surplus Lines License, State of Florida

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Patricia B. Jenkins, CPSR
Public Risk Specialist

EXPERIENCE

Public Risk Insurance Advisors
June 2010 to present. Public Risk Specialist
Responsibilities include working with mid-sized to large public entity clients. Handle requests for certificates of insurance, policy changes and endorsements, claims issues, and other daily servicing duties. Provide technical and clerical support for public entity service representatives.

N.T. Vincent Insurance
2000-2010. Commercial and Personal Lines Account Manager. Managed several different lines of insurance such as Workers' Compensation, General Liability, Commercial Property, etc. Administered clients. New business sales. Cross-selling. Processed accounting information.

Allstate Insurance Company
1998-2000. Office Manager/Commercial and Personal Lines Account Manager. Handled Customer Relations. New Business Sales. Cross-selling. Managed Office. Duties included day-to-day activities including certificates of insurance, request endorsements, process new business, renewals, etc. Managed Staff.

Caton Insurance Agency, Inc.
1996-1998 Commercial Lines Account Manager. Managed $2 million book of business. Created renewal retention reports. Worked with Senior VP as agent. Created proposals for clients. Handle requests for endorsements, certificates, policy checking for accuracy, etc.

LICENSES

2-20 General Lines Agent, State of Florida

EDUCATION

Collin County Community College
Certified Professional Service Representative, CPSR

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Michelle Y. Martin, CIC
Vice President / Public Risk Advisor

EXPERIENCE

Public Risk Insurance Advisors
2005 to Present. Vice President / Public Risk Advisor
Responsibilities include direct consulting with clients to identify and analyze risk exposures and coverage needs and develop and design individualized insurance programs. Professional client services include oversight of insurance and risk management programs, including claims advocacy, internal policy and procedures development, and contract review. Effective and efficient communication methods for elected board presentations, committee meeting participation, and coordination of daily staff service needs.

Brown & Brown, Inc.
2004 to 2005. Vice President, Risk Management Division/Account Executive. Developed this division to enhance risk management services, cultivate new and existing client relationships, and concentrate marketing efforts for the agency's largest commercial accounts and other niche business, including governmental entities. Programs concentrated in National Accounts, Alternative Risk Finance Techniques, and Self-Insurance.

2002 to 2004. Vice President, Marketing Manager. Responsible for $170M+ of premium volume for existing commercial and public entity accounts.

1994 to 2002. Account Executive. Focused on large account management, including business development, marketing and client relations/service.

1990 to 1994. Technical Assistant and Marketing Analyst. Handled large commercial and public entity insurance service, policy marketing, and quality control functions.

EDUCATION

University of Central Florida, B.A. Business Administration/Finance
Certified Insurance Counselor (CIC)
Risk Management for Public Entities (RMPE)
Candidate for Associates in Risk Management (ARM)

LICENSES

2-20 General Lines Agents License, State of Florida

PROFESSIONAL AFFILIATIONS

RIMS – Risk and Insurance Management Society
PRIMA – Public Risk and Insurance Management Association
FGFOA – Florida Government Finance Officer Association; Q
Past: The Chamber, Daytona Beach/Halifax Area – Board of Directors, Executive Director of Civic Ballet of Volusia County, President of Downtown Daytona Kiwanis, Board of Directors Literacy Council; Ormond Memorial Art Museum and Gardens Board

4.6.2.1 Evidence that the Respondent's Account Executive has at least 5 years' experience, prior to May 1, 2019, managing services for public entity medical, dental, workers' compensation and other insured employee benefits, as applicable, for similar-sized or larger public entities located in Florida. Such services may include account set-up, relationship/vendor management or customer service relationship management for clients.

The Team Leader for PRIA's Health Benefits team is Danielle Boyle. Ms. Boyle began her insurance career with PRIA in 2009. Danielle has managed large public entity clients for over 10 years including City of St Cloud, Stetson University, City of Deland, Broward County Housing Authority, City of New Smyrna Beach and others.

The Team Leader for PRIA's Property, Casualty and Workers' Compensation team is Paul Dawson. Mr. Dawson began his insurance career with PRIA in 1995. His focus has always been on the public entity sector in Florida consequently he has over 24 years of experience managing services and providing client consultation.

4.6.2.2 Evidence that Implementation Team members have at least two (2) years' experience, within the last five (5) years, prior to May 1, 2019, providing services related to medical, dental, workers' compensation and other insured employee benefits. Such services may include account set-up, relationship/vendor management or customer service relationship management for clients.

Every member of PRIA's team on both the Health Benefits and Property, Casualty, Workers' Compensation teams has more than 2 years of experience in providing the services listed in this response. More importantly this experience is entirely with public entities. Evidence of this can be found in their respective resumes and work experience with PRIA.

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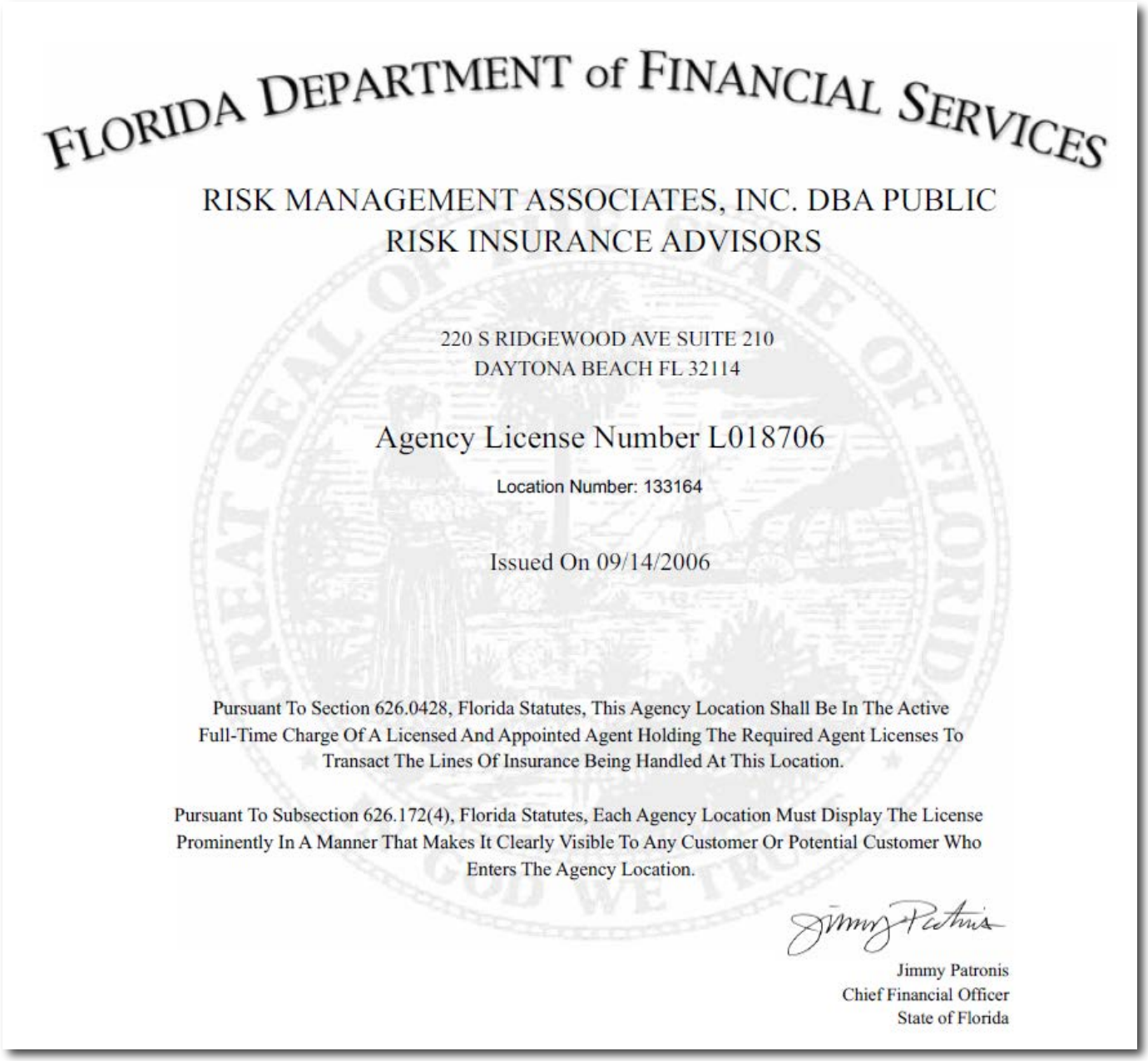
4.6.2.3 Evidence (copies of relevant licenses and certifications) that all members of the Implementation Team meet all licensing and/or certification requirements necessary to conduct business in the State of Florida with regard to the services requested herein.



FLORIDA DEPARTMENT of FINANCIAL SERVICES

RISK MANAGEMENT ASSOCIATES, INC. DBA PUBLIC RISK INSURANCE ADVISORS

220 S RIDGEWOOD AVE SUITE 210
DAYTONA BEACH FL 32114

Agency License Number L018706

Location Number: 133164

Issued On 09/14/2006

Pursuant To Section 626.0428, Florida Statutes, This Agency Location Shall Be In The Active Full-Time Charge Of A Licensed And Appointed Agent Holding The Required Agent Licenses To Transact The Lines Of Insurance Being Handled At This Location.

Pursuant To Subsection 626.172(4), Florida Statutes, Each Agency Location Must Display The License Prominently In A Manner That Makes It Clearly Visible To Any Customer Or Potential Customer Who Enters The Agency Location.

Jimmy Patronis
Chief Financial Officer
State of Florida

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FLORIDA DEPARTMENT OF FINANCIAL SERVICES

DANIELLE LEIGH BOYLE
License Number : P192659

Resident Insurance License	Issue Date
• 0215 - LIFE INCL VAR ANNUITY & HEALTH	05/12/2009

Please Note: A licensee may only transact insurance with an active appointment by an eligible insurer or employer. If you are acting as a surplus lines agent, public adjuster, or reinsurance intermediary manager/broker, you should have an appointment recorded in your own name on file with the Department. If you are unsure of your license status you should contact the Florida Department of Financial Services immediately. This license will expire if more than 48 months elapse without an appointment for each class of insurance listed. If such expiration occurs, the individual will be required to re-qualify as a first-time applicant. If this license was obtained by passing a licensure examination offered by the Florida Department of Financial Services, the licensee is required to comply with continuing education requirements contained in 626.2815 or 648.385, Florida Statutes. A licensee may track their continuing education requirements completed or needed in their MyProfile account at https://dice.fldfs.com. To validate the accuracy of this license you may review the individual license record under "Licensee Search" on the Florida Department of Financial Services website at http://www.MyFloridaCFO.com/Division/Agents

Jeff Atwater
Chief Financial Officer
State of Florida

FLORIDA DEPARTMENT OF FINANCIAL SERVICES

MELANIE K STEGALL
License Number : W295406

Resident Insurance License	Issue Date
• 0215 - LIFE INCL VAR ANNUITY & HEALTH	12/08/2015

Please Note: A licensee may only transact insurance with an active appointment by an eligible insurer or employer. If you are acting as a surplus lines agent, public adjuster, or reinsurance intermediary manager/broker, you should have an appointment recorded in your own name on file with the Department. If you are unsure of your license status you should contact the Florida Department of Financial Services immediately. This license will expire if more than 48 months elapse without an appointment for each class of insurance listed. If such expiration occurs, the individual will be required to re-qualify as a first-time applicant. If this license was obtained by passing a licensure examination offered by the Florida Department of Financial Services, the licensee is required to comply with continuing education requirements contained in 626.2815 or 648.385, Florida Statutes. A licensee may track their continuing education requirements completed or needed in their MyProfile account at https://dice.fldfs.com. To validate the accuracy of this license you may review the individual license record under "Licensee Search" on the Florida Department of Financial Services website at http://www.MyFloridaCFO.com/Division/Agents

Jeff Atwater
Chief Financial Officer
State of Florida

FLORIDA DEPARTMENT OF FINANCIAL SERVICES

FRANCENE MARRA
License Number : W132492

Resident Insurance License	Issue Date
• 0215 - LIFE INCL VAR ANNUITY & HEALTH	02/27/2013

Please Note: A licensee may only transact insurance with an active appointment by an eligible insurer or employer. If you are acting as a surplus lines agent, public adjuster, or reinsurance intermediary manager/broker, you should have an appointment recorded in your own name on file with the Department. If you are unsure of your license status you should contact the Florida Department of Financial Services immediately. This license will expire if more than 48 months elapse without an appointment for each class of insurance listed. If such expiration occurs, the individual will be required to re-qualify as a first-time applicant. If this license was obtained by passing a licensure examination offered by the Florida Department of Financial Services, the licensee is required to comply with continuing education requirements contained in 626.2815 or 648.385, Florida Statutes. A licensee may track their continuing education requirements completed or needed in their MyProfile account at https://dice.fldfs.com. To validate the accuracy of this license you may review the individual license record under "Licensee Search" on the Florida Department of Financial Services website at http://www.MyFloridaCFO.com/Division/Agents

Jimmy Patronis
Chief Financial Officer
State of Florida

FLORIDA DEPARTMENT OF FINANCIAL SERVICES

MORGAN MICHELLE JOHNSON
License Number : W393927

Resident Insurance License	Issue Date
• 0215 - LIFE INCL VAR ANNUITY & HEALTH	04/13/2017

Please Note: A licensee may only transact insurance with an active appointment by an eligible insurer or employer. If you are acting as a surplus lines agent, public adjuster, or reinsurance intermediary manager/broker, you should have an appointment recorded in your own name on file with the Department. If you are unsure of your license status you should contact the Florida Department of Financial Services immediately. This license will expire if more than 48 months elapse without an appointment for each class of insurance listed. If such expiration occurs, the individual will be required to re-qualify as a first-time applicant. If this license was obtained by passing a licensure examination offered by the Florida Department of Financial Services, the licensee is required to comply with continuing education requirements contained in 626.2815 or 648.385, Florida Statutes. A licensee may track their continuing education requirements completed or needed in their MyProfile account at https://dice.fldfs.com. To validate the accuracy of this license you may review the individual license record under "Licensee Search" on the Florida Department of Financial Services website at http://www.MyFloridaCFO.com/Division/Agents

Jimmy Patronis
Chief Financial Officer
State of Florida

FLORIDA DEPARTMENT OF FINANCIAL SERVICES

BRANDON SAVAGE
License Number : P187689

Resident Insurance License	Issue Date
• 0215 - LIFE INCL VAR ANNUITY & HEALTH	04/04/2009

Please Note: A licensee may only transact insurance with an active appointment by an eligible insurer or employer. If you are acting as a surplus lines agent, public adjuster, or reinsurance intermediary manager/broker, you should have an appointment recorded in your own name on file with the Department. If you are unsure of your license status you should contact the Florida Department of Financial Services immediately. This license will expire if more than 48 months elapse without an appointment for each class of insurance listed. If such expiration occurs, the individual will be required to re-qualify as a first-time applicant. If this license was obtained by passing a licensure examination offered by the Florida Department of Financial Services, the licensee is required to comply with continuing education requirements contained in 626.2815 or 648.385, Florida Statutes. A licensee may track their continuing education requirements completed or needed in their MyProfile account at https://dice.fldfs.com. To validate the accuracy of this license you may review the individual license record under "Licensee Search" on the Florida Department of Financial Services website at http://www.MyFloridaCFO.com/Division/Agents

Jeff Atwater
Chief Financial Officer
State of Florida

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FLORIDA DEPARTMENT OF FINANCIAL SERVICES

WILLIAM PAUL DAWSON
License Number : A063548

Resident Insurance License	Issue Date
• 0220 - GENERAL LINES (PROP & CAS)	04/22/1999

Please Note: A licensee may only transact insurance with an active appointment by an eligible insurer or employer. If you are acting as a motorist lines agent, public adjuster, or reinsurance intermediary manager/broker, you should have an appointment recorded in your own name on file with the Department. If you are unsure of your license status you should contact the Florida Department of Financial Services immediately. This license will expire if more than 60 months elapse without an appointment for each class of insurance listed. If such expiration occurs, the individual will be required to re-qualify as a first-time applicant. If this license was obtained by passing a licensure examination offered by the Florida Department of Financial Services, the licensee is required to comply with continuing education requirements contained in 626.2815 or 648.385, Florida Statutes. A licensee may track their continuing education requirements completed, or needed in their MyProfile account at https://dfsx.fldfs.com. To validate the accuracy of this license you may review the individual license record under "Licensee Search" on the Florida Department of Financial Services website at http://www.MyFloridaCFO.com/Division/Agents

Jimmy Patronis
Chief Financial Officer
State of Florida

FLORIDA DEPARTMENT OF FINANCIAL SERVICES

ROBIN LEE RUSSELL
License Number : A295946

Resident Insurance License	Issue Date
• 0215 - LIFE INCL VAR ANNUITY & HEALTH	08/16/2002
• 0120 - SURPLUS LINES	10/16/2006
• 0220 - GENERAL LINES (PROP & CAS)	07/02/1998

Please Note: A licensee may only transact insurance with an active appointment by an eligible insurer or employer. If you are acting as a motorist lines agent, public adjuster, or reinsurance intermediary manager/broker, you should have an appointment recorded in your own name on file with the Department. If you are unsure of your license status you should contact the Florida Department of Financial Services immediately. This license will expire if more than 60 months elapse without an appointment for each class of insurance listed. If such expiration occurs, the individual will be required to re-qualify as a first-time applicant. If this license was obtained by passing a licensure examination offered by the Florida Department of Financial Services, the licensee is required to comply with continuing education requirements contained in 626.2815 or 648.385, Florida Statutes. A licensee may track their continuing education requirements completed, or needed in their MyProfile account at https://dfsx.fldfs.com. To validate the accuracy of this license you may review the individual license record under "Licensee Search" on the Florida Department of Financial Services website at http://www.MyFloridaCFO.com/Division/Agents

Jimmy Patronis
Chief Financial Officer
State of Florida

FLORIDA DEPARTMENT OF FINANCIAL SERVICES

PATRICIA BRIANNA JENKINS
License Number : A230015

Resident Insurance License	Issue Date
• 0220 - GENERAL LINES (PROP & CAS)	01/30/2012

Please Note: A licensee may only transact insurance with an active appointment by an eligible insurer or employer. If you are acting as a motorist lines agent, public adjuster, or reinsurance intermediary manager/broker, you should have an appointment recorded in your own name on file with the Department. If you are unsure of your license status you should contact the Florida Department of Financial Services immediately. This license will expire if more than 60 months elapse without an appointment for each class of insurance listed. If such expiration occurs, the individual will be required to re-qualify as a first-time applicant. If this license was obtained by passing a licensure examination offered by the Florida Department of Financial Services, the licensee is required to comply with continuing education requirements contained in 626.2815 or 648.385, Florida Statutes. A licensee may track their continuing education requirements completed, or needed in their MyProfile account at https://dfsx.fldfs.com. To validate the accuracy of this license you may review the individual license record under "Licensee Search" on the Florida Department of Financial Services website at http://www.MyFloridaCFO.com/Division/Agents

Jimmy Patronis
Chief Financial Officer
State of Florida

FLORIDA DEPARTMENT OF FINANCIAL SERVICES

MICHELLE YVETTE MARTIN
License Number : A166553

Resident Insurance License	Issue Date
• 0220 - GENERAL LINES (PROP & CAS)	08/06/1994

Please Note: A licensee may only transact insurance with an active appointment by an eligible insurer or employer. If you are acting as a motorist lines agent, public adjuster, or reinsurance intermediary manager/broker, you should have an appointment recorded in your own name on file with the Department. If you are unsure of your license status you should contact the Florida Department of Financial Services immediately. This license will expire if more than 60 months elapse without an appointment for each class of insurance listed. If such expiration occurs, the individual will be required to re-qualify as a first-time applicant. If this license was obtained by passing a licensure examination offered by the Florida Department of Financial Services, the licensee is required to comply with continuing education requirements contained in 626.2815 or 648.385, Florida Statutes. A licensee may track their continuing education requirements completed, or needed in their MyProfile account at https://dfsx.fldfs.com. To validate the accuracy of this license you may review the individual license record under "Licensee Search" on the Florida Department of Financial Services website at http://www.MyFloridaCFO.com/Division/Agents

Jimmy Patronis
Chief Financial Officer
State of Florida

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4.6.3 Brief description of the level of service and support Implementation Team Members will provide on an on-going (day-to-day) basis. (Maximum of two (2) pages)

A. Health

PRIA strives to consistently provide a concierge level of service to our clients daily. We service solely public entities in the State of Florida and have a unique understanding of the challenges our clients face. PRIA is a team of 20 licensed insurance professionals that are cross trained to ensure a superior level of client service. Our Employee Benefits Team meets weekly to discuss any client issues, resolutions, timelines for upcoming client events, etc. These meetings ensure we are all on the same page with what is happening with all our clients.

Where implementation is concerned, PRIA will be as involved as our clients allow us to be. During an implementation, we typically provide support for all conference calls, in-person meetings, document reviews and any other support the District may need for a successful implementation. We will hold employee meetings / seminars, if necessary, to ensure understanding of any new product, service or carrier / vendor. The PRIA team is always available on an ongoing basis as well for any staff and / or employee questions or assistance.

B. Property & Casualty and C. Workers' Compensation

Although we have more than 10,000 teammates worldwide and more than 300 in our Daytona home office, the PRIA team itself is comprised of 20 insurance professionals. Those 20 teammates are solely focused on servicing PRIA clients which are exclusively governmental entities within the State of Florida. This is an important and distinct advantage for our clients; by creating a team which focuses exclusively on public risk programs, our capabilities and results are unrivaled in the State and our clients enjoy the highest level of customized service and expertise.

The entire team of insurance professionals at PRIA are cross trained and educated on all accounts in order to maintain continuity and exceptional service standards. PRIA's proactive approach includes establishing a calendar of events with our clients which maintains the insurance program in real-time and assures that PRIA is aware of and available for important meetings or events. This includes communication expectations and reporting requirements. It is our service model to immediately identify and document client expectations in order to meet those needs on a daily and on-going basis.

Our service team is specifically trained to anticipate the next item on the client timeline during the policy year and the renewal period. They are provided a thorough checklist, which includes the scope of services defined herein and those that may rise to the level of importance deemed by the insured. This checklist is a guide that is to be strictly adhered to. Each member of the team is held accountable to our corporate wide quality control standards. Checks and balances have been established in our organization that allows for multiple team members to be aware of upcoming needs of an insured. Our timeline provides ample opportunity to be ready for the unexpected as well as present renewals and other important service items in a timely manner.

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Your team leader, Paul Dawson, meets with the service staff regularly We send systematic reminders to clients regarding outstanding items and work closely with them to obtain underwriting data to ensure our quote, proposal and meeting timelines are adhered to.

4.7 PERFORMANCE REQUIREMENTS.

4.7.1 The Respondent shall adhere to the performance standards in the Performance Schedules specified in section 3.3 of Part III, A. Health Insurance Broker and/or Part III, B. Property and Casualty Broker and/or Part III, C. Workers' Compensation Broker.

Agree.

4.7.2 All communications marked "urgent" will be responded to on the same day. All phone calls will be returned within 24 hours.

Agree.

4.7.3 All communications requiring a response will be responded to within three (3) business days of receipt, even if only by an acknowledgement.

Agree.

4.7.4 All meetings with the District where decisions are scheduled to be made, commitments are scheduled to be made, technical advice is scheduled to be given or information is scheduled to be exchanged will be confirmed in writing (email or letter) to the District at least seven (7) business days prior to the meeting date. The District may waive this requirement when conditions do not allow the required notice to be given.

Agree.

4.7.5 Cooperate fully with State of Florida auditors concerning any confirmation or other information necessary to complete an audit.

Agree.

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Section 4
References

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Section 4: References

4.8.1 Respondent must provide at least five (5) separate, relevant, and verifiable references for Florida public entities that use the Respondent's proposed services for Health and/or Property and Casualty and/or Workers' Compensation insurance. Each reference must be able to comment on Respondent's relevant experience. References must be public entities of similar size or larger than the District. The District cannot be used as a reference

4.8.2 For each reference, please submit a summary sheet indicating: 4.8.2.1 Name of the entity
4.8.2.2 Number of covered members (employees, dependents, retirees, etc.)
4.8.2.3 Time period during which services were provided
4.8.2.4 Type of benefit programs addressed
4.8.2.5 Summary and scope of work provided by Respondent
4.8.2.6 Contact name, address, e-mail address and phone number

A. Health

Client Name:	**City of Sarasota**
Address:	111 S. Orange Ave., Sarasota, FL 34236
Client Contact:	Stacie Mason, HR Director
Telephone Number:	(941) 951-3634
Email:	Stacie.mason@sarasotafl.gov
Assigned Team:	Danielle Boyle, Francene Marra, Brandon Savage
Benefit Programs:	Self-Funded Health, ASO, Stop Loss, Health Care Center, Dental, Vision, Life, Supplemental
Scope of Services:	Employee Benefits brokerage and consulting services including: negotiations with insurers; budget recommendations; quarterly claims reviews, monthly claims dashboards; RFP management; cost control recommendations; claims assistance; wellness program design and implementation; committee meetings; onsite clinic coordination; presentations to leadership.
Size of Entity:	658 Employees / 523 Retirees
Time Period:	2016 - Present

Client Name:	**City of St Cloud**
Address:	1300 Ninth St., Building B, St. Cloud, FL 34769
Client Contact:	Joe Etter, HR Director
Telephone Number:	(407) 957-7209
Email:	jetter@stcloud.org
Assigned Team:	Danielle Boyle, Francene Marra, Brandon Savage
Benefit Programs:	Self-Funded Health, ASO, Stop Loss, Health Care Center, Dental, Vision
Scope of Services:	Employee Benefits brokerage and consulting services including: annual negotiations with insurers; budget recommendations; quarterly claims reviews, monthly claims dashboards; RFP management; cost control recommendations; claims assistance; wellness program design and implementation; Insurance Committee meetings; presentations to leadership.
Size of Entity:	532 Employees / 40 Retirees
Time Period:	2011 - Present

Client Name:	**City of Haines City**
Address:	620 E. Main Street, Haines City, FL 33844
Client Contact:	Tavia Conner, Finance Director, CPA, MBA
Telephone Number:	(863) 421-3600
Email:	sconner@hainescity.com
Assigned Team:	Tiffany White, Morgan Hathaway
Benefit Programs:	Self-Funded consortium health plan, ancillary lines of coverage.
Scope of Services:	PRIA serves as agent of record for the City of Haines City's self-funded medical program through our FGHS Consortium, dental, vision and life insurance plans. Services include: plan design consultation, claims monitoring, quarterly meetings to strategize regarding long term cost containment, wellness meetings and health fairs, RFP process management, proposal evaluation, enrollment meetings and employee communication materials. PRIA is also a day-to-day resource for claims and billing assistance, compliance and regulatory guidance and enrollment tracking.
Size of Entity:	254 Employees
Time Period:	2014 – Present

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Client Name:	**City of Palm Coast**
Address:	160 Lake Ave., Palm Coast, FL 32164
Client Contact:	Debbie Streichsbier, Human Resources Director
Telephone Number:	(386) 986-3725
Email:	dstreichsbier@palmcoastgov.com
Assigned Team:	Julie Freidus, Brandon Savage, Teri Kovaleski, Laurie Nelson
Benefit Programs:	Self-Funded Health, ASO, Stop Loss, Near Site Clinic, Dental, Life, Disability
Scope of Services:	Brown & Brown serves as agent of record for the City of Palm Coast's self-funded medical program. Services include: plan design consultation, claims monitoring, quarterly meetings to strategize regarding long term cost containment, wellness meetings and health fairs, RFP process management, proposal evaluation, enrollment meetings and employee communication materials. Brown & Brown is also a day-to-day resource for claims and billing assistance, compliance and regulatory guidance and enrollment tracking.
Size of Entity:	400 Employees
Time Period:	2001 – Present

Client Name:	**Flagler County School Board**
Address:	1769 East Moody Blvd, Bldg #2, Bunnell, FL 32110
Client Contact:	Ben Osypian, Chief Human Resources Officer
Telephone Number:	(386) 437-7526 x 1165
Email:	osypianb@flaglerschool.com
Assigned Team:	Julie Freidus, Brandon Savage, Teri Kovaleski, Laurie Nelson
Benefit Programs:	Self-Funded Health, ASO, Stop-Loss, Near Site Clinic, Dental, Vision, Life, Disability
Scope of Services:	Employee Benefits brokerage and consulting services including: annual negotiations with insurers; budget recommendations; quarterly claims reviews, monthly claims dashboards; RFP management; clinic RFP, implementation, and ongoing monitoring of clinic; cost control recommendations; claims assistance; wellness program design and implementation; Council meetings; open enrollment services to include benefits guides and presentations to employees
Size of Entity:	1650 Employees
Time Period:	2010 – Present

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B. Property & Casualty and C. Workers' Compensation

Client Name:	**City of Sarasota**
Address:	111 S. Orange Ave., Sarasota, FL 34236
Client Contact:	Stacie Mason, HR Director
Telephone Number:	(941) 951-3634
Email:	Stacie.mason@sarasotafl.gov
Assigned Team:	Paul Dawson, Brittany O'Brien
P&C Programs:	All Property, Casualty and Workers' Compensation Lines
Scope of Services:	PRIA has also served as the City's Property & Casualty and Workers' Compensation agent since 2009. The City's program includes fully insured and self-insured programs.
Size of Entity:	658 Employees / 523 Retirees
Time Period:	2009 – Present

Client Name:	**City of Haines City**
Address:	620 E. Main Street, Haines City, FL 33844
Client Contact:	Tavia Conner, Finance Director, CPA, MBA
Telephone Number:	(863) 421-3600
Email:	sconner@hainescity.com
Assigned Team:	Paul Dawson, Melody Blake
P&C Programs:	All Property, Casualty and Workers' Compensation Lines
Scope of Services:	PRIA has successfully managed the Property and Casualty insurance for the City since 2005.
Size of Entity:	254 Employees
Time Period:	2005 – Present

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Client Name:	**City of St Cloud**
Address:	1300 Ninth St., Building B, St. Cloud, FL 34769
Client Contact:	Harvey Bisson, HR Director
Telephone Number:	(407) 957-7359
Email:	hbisson@stcloud.org
Assigned Team:	Paul Dawson, Danielle Coggon
P&C Programs:	All Property, Casualty and Workers' Compensation Lines
Scope of Services:	PRIA has successfully managed the City's Property & Casualty and Workers' Compensation agent since 1996. The City's program includes fully insured and self-insured programs.
Size of Entity:	532 Employees / 40 Retirees
Time Period:	1996 – Present

Client Name:	**Clay County BOCC**
Address:	477 Houston Street, Green Cove Springs, FL 32043
Client Contact:	Jennifer Rupert-Bethelmy
Telephone Number:	(904) 529-3867
Email:	jennifer.bethelmy@claycountygov.com
Assigned Team:	Paul Dawson, Melody Blake
P&C Programs:	All Property, Casualty and Workers' Compensation Lines
Scope of Services:	PRIA has successfully managed the City's Property & Casualty and Workers' Compensation agent since 2006. The City's program includes fully insured and self-insured programs.
Size of Entity:	1,538 Employees
Time Period:	2006 – Present

Client Name:	**City of Ocala**
Address:	110 SE Watula Avenue, 3rd Floor, Ocala, FL 34471
Client Contact:	Jared Sorensen
Telephone Number:	(352) 401-3991
Email:	jsorensen@ocalafl.org
Assigned Team:	Paul Dawson, Danielle Coggon
P&C Programs:	All Property, Casualty and Workers' Compensation Lines
Scope of Services:	PRIA has successfully managed the City's Property & Casualty and Workers' Compensation agent since 1996. The City's program includes fully insured and self-insured programs.
Size of Entity:	1,127 Employees
Time Period:	1996 – Present

Client Name:	**St. Johns River Water Management District**
Address:	601 South Lake Destiny Road, Maitland, FL 32751
Client Contact:	Joseph Lambert
Telephone Number:	(407) 659-4886
Email:	jlambert@sjrwmd.com
Assigned Team:	Paul Dawson, Trish Jenkins
P&C Programs:	All Property, Casualty and Workers' Compensation Lines
Scope of Services:	PRIA has successfully managed the Property and Casualty insurance for the City since 1997.
Size of Entity:	514 Employees
Time Period:	1997 – Present

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Section 5

Scope of Work

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Section 5: Scope of Work

A description of the other resources and capabilities within your firm, with special emphasis on safety and loss control, including a resume of the safety/loss control specialist(s).

PART III – NATURE OF SERVICES REQUIRED A. HEALTH INSURANCE BROKER		
3.1 Project Description	**Agree**	**Disagree**
The District seeks the services of a Florida Licensed Health Insurance Broker to serve as a liaison between the insurance companies and the District. These services will include, but shall not be limited to, assisting the District in the selection of health insurance plans, contract administration, customer service for administration and claims, compliance reviews and proactive input on health insurance related concerns. The selected Respondent must assist the District with the solicitation, review, negotiation and implementation of cost-effective employee benefits insurance plans to be offered to District employees.	✓	
3.2 Scope of Work	**Agree**	**Disagree**
3.2.1 Assist in determining specifications for future medical, dental and other insured employee benefits coverage including but not limited to life insurance, accidental death and disability, long term disability, vision, supplemental, discounted programs, health and wellness, etc.	✓	
3.2.2 Assist with development of procurement documents in accordance with District specifications and procurement procedures.	✓	
3.2.3 Assist with identification of appropriate markets for desired medical, dental and other insured employee benefits.	✓	
3.2.4 Analyze and evaluate medical, dental and other insured employee benefits products submitted for consideration by providers and provide options and make recommendations.	✓	
3.2.5 Assist with contract negotiation.	✓	
3.2.6 Audit resulting contracts for accuracy of coverage and contract compliance.	✓	
3.2.7 Regularly assess current market trends involving employee benefits.	✓	
3.2.8 Assist with annual medical, dental and other insured employee benefits procurements and renewals, including negotiation of changes in contracts in accordance with the terms of the provider's solicitation.	✓	

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3.2 Scope of Work		Agree	Disagree
3.2.9	Provide thorough analysis and recommendations for medical, dental and other insured employee benefits for quality of benefits provided, cost effectiveness, competitiveness and plan administration on an annual basis.	✓	
3.2.10	Maintain active and ongoing communications with the providers to ensure smooth operation and delivery of benefits, as well as facilitating prompt review and resolution of plan and claims administration issues.	✓	
3.2.11	Provide a dedicated customer service team to answer questions and resolve issues that arise during the year regarding employee benefits, contract administration, and service provisions.	✓	
3.2.12	Provide plan design and financial management performance updates for all brokered benefit plans, at least quarterly, via detailed analysis, review, and evaluation of costs, claims, and trends.	✓	
3.2.13	Provide "Annual Stewardship Report," which will include complete accounting of fees and commissions earned on the account, observations on relevant changes in the insurance market, view on loss exposures facing the District and loss control activities.	✓	
3.2.14	Serve as a resource to District staff on Federal and State benefits laws, including but not limited to: COBRA, HIPAA, FMLA, the Affordable Health Care Act, ADA, etc.	✓	
3.2.15	Promptly inform District staff of changing legislation and legal decisions affecting employee benefits and consult with District's Office of General Counsel on methods of compliance.	✓	
3.2.16	Assist with legally required reporting and compliance with statutes, rules, regulations and codes, including required employee communications and notices.	✓	
3.2.17	Make regularly scheduled visits to District service offices to provide information and guidance, respond to questions, solve problems, and assist with benefit administration.	✓	
3.2.18	Assist in the development of the annual open enrollment benefits package and participate in open enrollment meetings for all employees.	✓	
3.2.19	Assist with development of year-round informational and wellness materials, communications, employee meetings, health events (such as health fairs and screenings), etc. to maximize employees' knowledge and understanding of how to be the best consumer of the employee benefits plan.	✓	
3.2.20	Provide on-site employee enrollment meetings for new hires.	✓	

3.3 Performance Schedule	Agree	Disagree
Respondents must be able to meet the District's timeline.	✓	

3.3 Timeline

January	Execution of Brokerage Agreement.
February (when and if needed)	Finalize and issue an Invitation to Negotiate (ITN) for Employee Benefits Insurance Plans.
April	Receive and review responses from providers
July	If ITN for new coverage is not needed, begin renewal process for existing insurance plans to renew Jan. 1 the following year.
August	Get new providers in place and begin transition activities and implementation of new plan(s).
August and September	Coordinate with selected Respondent, provider(s) and the District's Information Technology Bureau (ITB) to set up structure of new plan(s) in system and perform operational and data transfer testing, troubleshooting, and issue resolution; Begin preparing communication to employees regarding upcoming open enrollment, with assistance of Broker and provider(s).
October	Communicate details of new plan(s) to employees and retirees through Internal Communications, *Currents*, employee open enrollment meetings, with assistance of the District and provider(s).
November and December	Assist with testing files between Human Resource Information System (HRIS) and provider sites and set up for Jan. 1 launch.
Late November – early December	Communication of plan enrollment verification details and legally required information, issuance of new insurance cards, etc., from medical and dental provider(s) to employees, retirees and dependents.
January 1	New health insurance plan year begins.

PART III – NATURE OF SERVICES REQUIRED (continued) B. PROPERTY AND CASUALTY BROKER		
3.1 Project Description	**Agree**	**Disagree**
The District seeks the services of a Florida Licensed Property and Casualty Broker to assist the District with the development of a strategic plan for the design, negotiation, analysis, monitoring, measurement and administration of the most cost-effective, best valued broker services. The selected Respondent will assist the District with the solicitation, review, negotiation and implementation of cost-effective property and casualty services.	✓	
3.2 Scope of Work	**Agree**	**Disagree**
3.2.1 The selected Respondent shall work closely with the District's Risk Management staff to routinely evaluate risks and make recommendations for the appropriate mitigation of those risks in a cost-beneficial way, including:		
3.2.1.1 Analyze the District's exposure to loss, the adequacy of coverage and developing options on coverage whether or not currently purchased by the District.	✓	
3.2.1.2 Perform catastrophe or other modeling to determine levels of exposure to risks.	✓	
3.2.1.3 Assist the District in evaluating the appropriate levels for risk mitigation.	✓	
3.2.1.4 Advise the District on the various alternatives to handling risks through various forms of insurance, self-insurance, and deductible levels.	✓	
3.2.1.5 Advise the District on pertinent insurance matters and attend risk management meetings with the District as desired during the year.	✓	
3.2.1.6 Assist in the development of risk management policies and procedures for the District as requested.	✓	
3.2.1.7 Make recommendations for enhancing the risk and insurance management program, including providing input regarding coverage issues outside the current program and guidance regarding self-insurance.	✓	
3.2.1.8 Bind insurance coverage to the District beyond insurance expiration dates while renewal policies are being put into place.	✓	
3.2.1.9 Provide research assistance and consultation on risk management issues.	✓	
3.2.1.10 Promptly and accurately process insurance policy endorsements and other change requests as needed.	✓	

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3.2 Scope of Work		Agree	Disagree
3.2.1.11	At a minimum conduct an annual review with the Human Resources Office Chief of the premium/claims history of the District for the policies purchased.	✓	
3.2.1.12	Provide training to District Risk Management staff.	✓	
3.2.2	Assist with all tasks related to the annual renewal process for all property and casualty insurance coverages available including:		
3.2.2.1	Assist with a marketing plan to include competitively soliciting at least three (3) quotes from providers or administering a formal solicitation in accordance with District specifications and procurement procedures.	✓	
3.2.2.2	Assist the District in developing optional coverage and limit structures for property and casualty lines of coverage.	✓	
3.2.2.3	Review the District's property data and advise of any data elements needed for underwriting evaluations, including sufficiency of Construction, Occupancy, Protection and Exposure (COPE) data.	✓	
3.2.2.4	Advise the District of availability of coverage and alternative risk transfer mechanisms for casualty lines of coverage; and notify the District of any data elements needed for underwriting evaluations, after a review of claim data.	✓	
3.2.2.5	Advise the District of current market pricing and availability of insurance coverage at least four months prior to the expiration of insurance coverage then in effect.	✓	
3.2.2.6	Annually, analyze the insurance market conditions, taking into account other insurance programs competing with the District's program for insurance coverage, seasonable perils, reinsurance treaty dates and any other factors that may affect insurance availability and pricing, and advise the District of the best time to procure insurance coverage.	✓	
3.2.2.7	Annually, review the District's policy for possible changes/enhancements and to ensure that the policy's language, coverage and exclusions are consistent with the District's certificate of coverage.	✓	
3.2.2.8	Serve as subject matter experts to the District on upcoming insurance procurements; and formulate a price and coverage negotiating strategy to support the District's choice of the recommendations presented on the insurance procurement.	✓	

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3.2 Scope of Work		Agree	Disagree
3.2.2.9	Assist with the coordination of the renewal process and provide to the District a renewal notification detailing anticipated coverage, limit, retention and pricing changes at least three months prior to policy inception and each year thereafter during the contract period.	✓	
3.2.2.10	Assist with the drafting of the insurance specifications, compile underwriting information and other pertinent information with the input of the District.	✓	
3.2.2.11	Prepare formal market submissions for distribution to underwriters, submit the market submission to the District for distribution approval, and distribute the approved market submission to underwriters on behalf of the District in a timely manner.	✓	
3.2.2.12	Negotiate renewal terms, conditions and pricing on behalf of and in conjunction with the District; place all insurance coverage approved by the District.	✓	
3.2.2.13	If applicable, fully disclose the amount and percentage of commission to be paid by the selected Respondent to any excess insurance broker, intermediary or wholesaler used in the placement process, and state their relationship, if any, to the selected Respondent.	✓	
3.2.2.14	Report placement results to the District and bind coverage as directed by the District; and obtain all necessary binding documents in a timely and effective manner.	✓	
3.2.2.15	Check binders, policies and endorsements to ensure they are issued according to specifications before delivery to the District.	✓	
3.2.2.16	Forward binders to the District before or on the policy's effective date.	✓	
3.2.2.17	Issue endorsements and insurance certificates as may be needed based on the insurance program structure.	✓	

3.2 Scope of Work	Agree	Disagree
3.2.2.18 Provide an annual summary of program terms and costs to the District that includes: • market review that lists all carriers that were approached; • their AM Best rating; • insurer status (admitted or non-admitted); • marketing status (quoted, declined, accepted, bound); • quoted amounts/comments; • synopsis of current market conditions; • renewal results with comparisons to the expiring policies; • renewal program coverage quilt/mosaic; • a premium summary listing all carriers • amounts authorized, price, and sorted by coverage layer and detailing any assessments or surcharges; • summary of the District's exposures; • catastrophe modeling summary and results; • any disclosures customarily provided by the selected Respondent to the District at the time of renewal; and • provide a disclosure in the annual summary that no income other than the compensation allowed by the Agreement has been received by the Respondent for services provided during the period covered by the annual summary.	✓	

3.2 Scope of Work	Agree	Disagree
3.2.2.19 Provide policies to the District as soon as issued or received by the providers, or upon instructions by the District: • collect all policies; • consolidate policies into a binder and submit the binder to the District once all policies have been received; • ensure the timely billing of all documents and premiums; • In the event a Notice of Cancellation has been issued due to nonpayment of premium, act on the District's behalf to resolve the issue with the Insurer and maintain insurance coverage; • assist the District with exposure issues or insurance contract provisions as needed on an ongoing basis; • evaluate the commitment and financial stability of the provider on an ongoing basis; • notify the District of any changes in the provider's AM Best ratings; • notify the District of any additional coverage that may become available in the marketplace that could be advantageous to the District and assist in the procurement of such coverage as instructed by the District; as needed but at least semi-annually; • present market updates to keep the District informed of any conditions or developments that may affect existing policies or future insurance placements; • act as a liaison with the provider that requests property inspections; and • assist the District in responding to and implementing any recommendations made as a result of property inspections.	✓	
3.2.3 Claims Administration.		
3.2.3.1 Prepare and issue all certificates of insurance within 2 days of request or sooner when such request is specified as an emergency.	✓	
3.2.3.2 Coordinate notice of claims and/or losses to underwriters and act as a facilitator during the claim process.	✓	

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3.2 Scope of Work		Agree	Disagree
3.2.3.3	Work closely with providers and act as a liaison between the District and providers that are contracted by the District to assist in areas that include, but are not limited to, delivering provider policies to the District, handling invoice issues, and other issues that may arise.	✓	
3.2.3.4	Answer questions and resolve coverage issues related to policy coverage, work with the District's management, legal counsel and/or auditors to provide needed information and expertise.	✓	
3.2.3.5	Respond in a timely manner to audit inquiries and attend meetings related to audits involving risk management.	✓	
3.2.3.6	Advise the District of trends and/or changes in the insurance industry.	✓	
3.2.3.7	Make presentations to the District's Governing Board, Board committees or management.	✓	
3.2.3.8	Coordinate reporting of claims with third party administrators.	✓	
3.2.3.9	Review the District contracts to determine if additional risk exposures are present. Assist the District in re-evaluating insurance requirements for various contracts (design, construction and service). Review certain leases, agreements for insurance requirements, assumption of liability and other risk management issues.	✓	
3.2.3.10	Prepare and submit special reports, loss analyses, SOC_1 Type-2 report, etc.	✓	
3.2.3.11	Obtain proper return premiums, if required, necessitated by mid-term cancellations and validate any additional premiums for accuracy.	✓	
3.2.3.12	Coordinate the selection of a mutually agreed upon adjusting firm that has experience in adjusting catastrophic losses.	✓	
3.2.3.13	Forward notification provided by the District to the insurers of any large losses reported above thresholds to be established by the provider for individual and aggregate losses on a per occurrence basis.	✓	

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3.2 Scope of Work	Agree	Disagree
3.2.3.14 In the event that losses from an occurrence exceed the District's self-insured retention, act as an advocate for the District and as an intermediary between the District, providers and the mutually agreed upon adjusting firm to facilitate communications, data exchange and prompt resolution of claims.	✓	
3.2.3.15 Provide general assistance in the administration of the District's program.	✓	
3.2.3.16 Provide additional services as may be assigned in accordance with the agreement and this Part III Nature of Services Required, Subpart B. No work will be complete under additional service without prior written authorization from the District to perform the work.	✓	
3.2.4 Contract Manager.		
3.2.4.1 The selected Respondent's Lead Account Manager or Contract Manager must have one or more of the following certificates or accreditations: Chartered Property Casualty Underwriter (CPCU); Accredited Advisor in Insurance (AAI); Certified Insurance Counselor (CIC); Associate in Risk Management (ARM). The selected Respondent must employ individuals who are appropriately licensed and registered with the State of Florida. Only licensed and registered employees of the selected Respondent shall provide services under the Agreement.	✓	
3.2.4.2 At a minimum, the selected Respondent shall assign a Contract Manager to work directly with the District's designated Contract Manager and other staff in providing the services specified in the Agreement. The District's Contract Manager shall coordinate all activities between the District and the selected Respondent.	✓	
3.3 Performance Schedule	**Agree**	**Disagree**
Respondents must be able to meet the District's timeline.	✓	

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3.3 Timeline

October	Execution/Renewal of Brokerage Agreement.
June (when and if needed)	Finalize and issue an Invitation to Negotiate (ITN) for Property and Casualty Insurance Plans.
July-August	Receive and review responses from Property and Casualty Insurance Plans. Advise the District of current market pricing and availability of insurance coverage.
August 30th	Provide to the District a renewal notification detailing anticipated coverage, limit, retention and pricing changes. Get new providers in place and begin transition activities and implementation of new plan(s).
September	Communicate details of new plan(s) to stakeholders with assistance of the District and provider(s).
September	Coordination and execution of contracts or renewals with providers for Property and Casualty services.
October 1	New property and casualty insurance plan year begins.

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PART III – NATURE OF SERVICES REQUIRED (continued) C. WORKERS' COMPENSATION BROKER		
Project Description	**Agree**	**Disagree**
3.1 PROJECT DESCRIPTION. The District seeks the services of a Florida Licensed Workers' Compensation Broker to assist the District with the development of a strategic plan for the design, negotiation, implementation, analysis, monitoring, measurement and administration of the most cost-effective workers' compensation programs. The District is self-insured.	✓	
Scope of Work	**Agree**	**Disagree**
3.2.1 Audit stop loss contracts for accuracy of coverage, terms and conditions.		
3.2.2 Assist with annual workers' compensation renewals, including negotiation of changes in stop loss contracts.	✓	
3.2.3 Assist with development of procurement documents in accordance with District specifications and procurement procedures.	✓	
3.2.4 Assist with identification of appropriate markets for workers' compensation.	✓	
3.2.5 Analyze and evaluate workers' compensation products submitted for consideration by providers and provide options and make recommendations.	✓	
3.2.6 Review the quality of workers' compensation provided, cost effectiveness, competitiveness and administration on an annual basis.	✓	
3.2.7 Monitor ongoing stop loss contracts, including third party administrators, to ensure contract compliance.	✓	
3.2.8 Analyze claim history and utilization at least quarterly.	✓	
3.2.9 Provide information on workers' compensation issues, trends and proposed or new legislation.	✓	
3.2.10 Meet with the District staff as needed.	✓	
3.2.11 Provide a key contact person to answer questions and resolve issues that arise regarding employee workers' compensation, contract administration, and service provisions.	✓	
3.2.12 Perform other related consultation services as needed or requested.	✓	
3.3 Performance Schedule	**Agree**	**Disagree**
Respondents must be able to meet the District's timeline.	✓	

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3.3 Timeline

October	Execution of Brokerage Agreement.
June (when and if needed)	Finalize and issue an Invitation to Negotiate (ITN) for Workers' Compensation Insurance Plans.
July-August	Receive and review responses from Workers' Compensation Insurance Plans.
August 30th	Get new providers in place and begin transition activities and implementation of new plan(s).
September	Communicate details of new plan(s) to stakeholders with assistance of the District and provider(s).
September	Coordination and execution of contracts or renewals with providers for workers' compensation services.
October 1	New workers' compensation insurance plan year begins.

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Section 6
Compensation

Best & Final Offer
Submitted - December 13, 2019

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Section 6: Compensation

All-Inclusive Fee for PRIA Brokerage on All Proposed Services

We have broken down the compensation plan for each line individually below. In addition, if the District wishes to contract with PRIA for all three brokerage services (Health, Property, Casualty, and Workers compensation) **or any combination of our services**, we have provided bundled discounts in the below chart.

Proposed Fees / Commissions & Bundled Discounts Overview	
Coverage	Compensation
Health Only	See A. Below – Fee or Commission
Property & Casualty Only	See B. Below – Fee or Commission
Workers Compensation Only	See C. Below – Fee or Commission
Health + Property & Casualty	$165,000 Annual Fee ($20,000 Discount)
Health + Workers Compensation	$125,000 Annual Fee ($10,000 Discount)
Property & Casualty + Workers Compensation	$70,000 Annual Fee ($10,000 Discount)
Brokerage Services for All Lines (Health, Property & Casualty, and Workers Compensation)	$162,500 Annual Fee ($37,500 Discount)

A. HEALTH INSURANCE BROKER

Respondents shall submit a compensation plan for services detailed in this, Part III, A. Health Insurance Broker, disclosing any commissions anticipated to be received by Respondent from providers and vendors for work to be performed under this ITN. Include (if applicable) a detailed fee schedule for Implementation Team Members, as defined in Paragraph 4.6, and other anticipated costs. Respondents must propose both a commission-based compensation and a flat broker rate option.

PRIA proposes the following commissions for the scope of services outlined in our response:

Employee Benefits Insurance Program	
Coverage	Compensation
Cigna – ASO	$12.00 PEPM
Stop Loss Insurance	7%
Dental Insurance	5%
Vision Insurance	10%
Life Insurance	10%
Disability Insurance	10%
Supplemental Insurance	Standard Commissions
Actuarial, Analytics & Consulting Services	**Included** ($15,000 Savings)

If the District prefers a flat fee option, PRIA proposes the following:

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Employee Benefits Insurance Program – Flat Fee Option
$120,000 annually

B. PROPERTY AND CASUALTY BROKER

Respondents shall submit a compensation plan for services detailed in this Part III, B. Property and Casualty Broker, disclosing any commissions anticipated to be received by the Respondent from providers and vendors for work to be performed under this ITN. Include (if applicable) a detailed fee schedule for the Implementation Team members, as defined in Subparagraph 4.6, and other anticipated costs. In addition, Respondent may also submit a flat fee proposal option.

We are willing to accept traditional commissions from insurers; this would include all the services proposed in our response.

Property & Casualty Insurance Brokerage – Flat Fee Option
$65,000 Annually

C. WORKERS' COMPENSATION BROKER

It is the District's expectation that the workers' compensation brokerage fees and commissions for services detailed in Part III, C. Workers' Compensation Broker, will be borne by the selected provider.

We are willing to accept traditional commissions from insurers.

Workers Compensation Brokerage – Flat Fee Option
$15,000 Annually

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Section 7

Additional Data

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Section 7: Additional Data

Give any additional information which you feel is pertinent for consideration. This information will only be evaluated to the extent it supports the Respondent's qualification and experience to provide the services requested by this ITN.

A. Health

Included in this section you will find:

- A sample of a recent marketing process proposal for a current large, self-funded, public entity client that was conducted and presented by PRIA.
- A sample of a Benefit Guide PRIA created for distribution to current employees and new hires for a current public entity client.
- Employee Communications that PRIA has the ability to create for our clients.

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PRIA
PUBLIC RISK INSURANCE ADVISORS
PART OF THE BROWN & BROWN TEAM

A Proposal of Employee Benefits Coverage and Service

Client Name

Danielle Boyle
Vice President

Francene Marra
Employee Benefits Team Leader

Brandon Savage
Director of Analytics

Morgan Johnson
Marketing Specialist

Effective Date: January 1, 2020

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Public Risk Insurance Advisors

Brown & Brown is one of the largest and most respected independent insurance intermediaries in the nation, with over 80 years of continuous service. The Company is ranked as the sixth largest such organization in the United States by Business Insurance magazine.

Public Risk Insurance Advisors (PRIA), a wholly owned subsidiary of Brown & Brown, Inc., has established itself as one of the premier insurance services organizations for public entities in the United States. Our in-depth understanding of the unique risk exposures and operating environment of public entities allows us to tailor insurance products and services to effectively meet their needs. As the only independent insurance agency solely dedicated to the public entity market, we are uniquely qualified to meet and exceed the expectations of our clients. Our 20 years of insuring local governments has afforded us significant experience and insight into the unique challenges and constraints that our clients face.

As a Brown & Brown company, PRIA has access to hundreds of insurance markets nationwide. The buying power and premium leverage within the organization is surpassed by few agencies.

PRIA focuses on developing innovative approaches towards managing your risk. Cost effective insurance products, professional service, and commitment to client's needs are our primary goals. Proof of account satisfaction is reflected by a 97% business retention rate.

Employee Benefits is just one area of expertise we can provide. Our benefit programs include
Medical, Dental, Vision, Cobra, Life, Disability and Section 125 pre-tax reimbursement accounts just to name a few. We are able to provide fully insured programs for employers of all sizes and self funded programs to meet the special needs of employers interested in that type of arrangement. In addition to providing the insurance programs, we assist in the design, cost-containment, management and development of your employee benefit package.

All Employee Benefit clients are assigned an "In House" Employee Beefits Specialist to assist with Billing, Claims, Eligibility, Enrollment, or any other issues or questions that arise.

For our clients that opt for self insured programs, we not only provide the mentioned above, but also supply detailed reports to help you monitor your program closely. We also place the reinsurance, help design a plan to meet your needs and work closely with you and the Third Party administrator during the implementation as well as throughout the year to ensure the plan operates smoothly.

As for property and casualty, PRIA is a recognized leader in the area of professional liability, governmental and municipal insurance programs, pollutions liability and many other specialized areas of risk. All property and casualty clients are assigned an "In-House" Public Risl Specialist.

Commitment to Our Clients

The Employee Benefits Division at Pubic Risk Insurance Advisors is focused on providing you with the best products at the most competitive rates possible. We ensure a very high level of customer service by remaining involved with you after the plan's effective date.

In addition to the PRIA's Employee Benefits Advisor, all clients are assigned a team of dedicated service and marketing professionals committed to fast, efficient and friendly service during plan renewal and every other day of the year.

- We provide assistance with carriers to resolve any issues concerning policy administration, claims and billing.
- We provide expertise in designing, analyzing, and maintaining an employee benefits program that will help you attract and retain quality employees.
- We provide timely guidance on local and national trends in employee benefits and in the carrier marketplace.

As part of the 6th largest insurance broker in the country (as determined by Business Insurance magazine) we have the resources to partner with clients of all sizes and industries to maximize benefits and contain costs. The Employee Benefits Division in Daytona Beach, FL is fully automated and highly efficient in marketing plan renewals and new business. We have access to all local and national carriers, third party administrators, and other specialists in the employee benefits industry including:

Medical · Dental · Vision · Life · Disability Plans · Cafeteria Plans · 401(k) Plans · Self-funded and Partially Self-funded arrangements · Employee Assistance Programs · Voluntary (employee-paid) Long-Term Disability, Short-Term Disability, Dental and Accident & Sickness plans.

Phone

(386) 252-6176

(386) 845-9229 - Fax

Address

Public Risk Insurance Advisors
220 South Ridgewood Avenue
Daytona Beach, FL 32114

Website

www.bbpria.com

NYSE Listed: BRO

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Disclaimer Information

Public Risk Insurance Advisors Disclaimers and Disclosures:

• Brown & Brown makes every attempt to place coverage with carriers rated A- or better through A.M. Best, a national credit rating Advisors with a specific focus on the insurance industry. Additional information, including carrier ratings can be found at www.ambest.com. Brown & Brown cannot certify the financial soundness or stability of a company, so we encourage you to review the financial information for each carrier as found in one or more of the following sources before making a decision as to where to place your coverage: a state department of insurance website, A.M. Best Company website, or a carrier website.

• The analysis of the following plans is a summary. Please refer to the policy certificate for a full list of coverage and exclusions.

• The rates and benefits in this proposal are based upon underwriting factors which include, but are not limited to, the census provided, the effective date shown, the status of employees/dependents (i.e. actively at work, COBRA, FMLA), final enrollment, etc. If any of the aforementioned changes prior to the proposed effective date, the final provisions, including rates, for these plans may vary or result in the proposed plan to be withdrawn.

• If you select to change carriers, any existing plans with other carriers should not be cancelled until advised by Public Risk Insurance Advisors.

• This proposal may not be a complete listing of all available benefit options. Different benefit levels may be available.

• This presentation is the proprietary work product of Public Risk Insurance Advisors and is not authorized for further use or distribution.

• All insurance carriers have their own operating procedures. A change in carrier could affect certain benefits and coverage.

• Public Risk Insurance Advisors representatives are available to explain any items presented. It is assumed that the recipients of this proposal will seek an explanation of any items that may be in question.

• Public Risk Insurance Advisors representatives may from time to time provide guidance regarding certain requirements affecting health plans, including the requirements of federal and state health care reform legislation. Such guidance is based on good-faith interpretation of laws and regulations currently in effect, and is not intended to be a substitute for legal advice. Employers should contact their own legal counsel for advice regarding legal requirements.

• The network directories/facility lists obtained via paper directories or carrier websites may contain providers and facilities that are no longer participating in the insurance carriers' networks. We cannot be responsible for any changes to the provider/facility listings that are not reflected. To ensure that a specific provider or facility is still participating in the provider's preferred network, we recommend contacting the provider/facility directly.

• Failure to adhere to provisions of the Affordable Care Act (such as pay-or-play, employer reporting requirements, benefit mandates, etc.) may result in significant fees and penalties to the employer. For a more comprehensive explanation of what fees and penalties may apply to you, you may contact your Public Risk Insurance Advisors representative at any time.

• You are required to comply with Health Care Reform's Summary of Benefits & Coverage (SBC) distribution guidelines, which include requirements for SBC distribution at the plan renewal date. If an employee must enroll to continue coverage, the SBC must be provided when open enrollment materials are distributed. If enrollment materials are not distributed, employees must receive an SBC by the first day they are eligible to enroll. For insured plans, if coverage continues automatically for the next year, the SBC must be provided at least 30 days before the beginning of the new plan year. If the policy is not issued by that date, the SBC must be provided within seven business days once the information is available. Please refer to the Department of Health & Human Services' (HHS) official guidance for complete details regarding renewal and other SBC distribution guidelines.

• Compensation: In addition to the commissions or fees received by us for assistance with the placement, servicing, claims handling, or renewal of your insurance coverages, other parties, such as excess and surplus lines brokers, wholesale brokers, reinsurance intermediaries, underwriting managers and similar parties, some of which may be owned in whole or in part by Brown & Brown, Inc., may also receive compensation for their role in providing insurance products or services to you pursuant to their separate contracts with insurance or reinsurance carriers. That compensation is derived from your premium payments. Additionally, it is possible that we, or our corporate parents or affiliates, may receive contingent payments or allowances from insurers based on factors which are not client-specific, such as the performance and/or size of an overall book of business produced with an insurer. We generally do not know if such a contingent payment will be made by a particular insurer, or the amount of any such contingent payments, until the underwriting year is closed. That compensation is partially derived from your premium dollars, after being combined (or "pooled") with the premium dollars of other insured's that have purchased similar types of coverage. We may also receive invitations to programs sponsored and paid for by insurance carriers to inform brokers regarding their products and services, including possible participation in company-sponsored events such as trips, seminars, and advisory council meetings, based upon the total volume of business placed with the carrier you select. We may, on occasion, received loans or credit from insurance companies. Additionally, in the ordinary course of our business, we may receive and retain interest on premiums you pay from the date we receive them until the date of premiums are remitted to the insurance company or intermediary. In the event that we assist with placement and other details of arranging for the financing of your insurance premium, we may also receive a fee from the premium finance company.

Questions and Information Requests: Should you have any questions or require additional information, please contact this office at 386-252-6176 or, if you prefer, submit your question or request online at http://www.bbinsurance.com/customerinquiry.shtml.

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CURRENT GUIDE TO BEST'S RATINGS

Best's Rating:

Represents an opinion based on a company's financial strength, operating performance and market profile

Secure Best's Ratings: A++ to B+ (Superior to Good)
Vulnerable Best's Ratings: B to D (Fair to Poor)

Outlooks:

Positive = indicates possible rating upgrade due to favorable financial/market trend relative to the current rating level.

Not Rated Companies:

NR = Companies that are not rated by A.M. Best

Rating Modifiers:

u = Under Review (change in financial condition)
pd = Public Data (Insurers do not subscribe to Best's rating process)
s = Syndicate (operating at Lloyds)

Financial Size Categories:

Reflects the company's size based on its capital surplus and conditional reserve funds in millions of U.S. dollars, using the scale below:

FSC I	less than 1	less than 1 mill	FSC IX	250 to 500
FSC II	1 to 2	1 to 2	FSC X	500 to 750
FSC III	2 to 5	2 to 5	FSC XI	750 to 1,000
FSC IV	5 to 10	5 to 10	FSC XII	1,000 to 1,250
FSC V	10 to 25	10 to 25	FSC XIII	1,250 to 1,500
FSC VI	25 to 50	25 to 50	FSC XIV	1,500 to 2,000
FSC VII	50 to 100	50 to 100	FSC XV	greater than 2,000
FSC VIII	100 to 250	100 to 250	" -- "	unknown / not rated

A.M. BEST'S INSURANCE RATINGS & CARRIER WEBSITES

The insurance company providing coverage has the following A.M. Best Financial Rating:

A++ to D = Highest to Lowest Rating
XV to I = Largest to Smallest Rating

Not Rated Companies:

NR = Not rated by A.M. Best

Carrier Name	Best's Rating for Stability	FSC Rating for Assets/ Surplus	Web Address	Provider Directory
Aetna Life Insurance Company	A	XV	www.aetna.com	Yes
Aetna Health Inc.	A	XV	www.aetna.com	Yes
Blue Cross & Blue Shield of Florida, Inc. (dba Florida Blue)	A+	XV	www.floridablue.com	Yes
Cigna Health and Life Insurance Company	A	XV	www.cigna.com	Yes
CIGNA HealthCare (underwitten by Life Ins Co of North America)	A	XV	www.cigna.com	Yes
Florida Combined Life Insurance Company	A	IX	www.bcbsfl.com	N/A
Guardian Life Insurance Company of America	A++	XV	www.glic.com	Yes
Humana Health Insurance of Florida, Inc. (PPO , EPO, Indemnity Plans)	A-	XV	www.humana.com	Yes
Humana Insurance Company (Ancillary)	A-	XV	www.humana.com	Yes
Lincoln National Life Insurance Company	A+	XV	www.lfg.com	Yes
Metropolitan Life Insurance Company	A+	XV	www.metlife.com	Yes
Standard Insurance Company	A	XIII	www.standard.com	N/A
Sun Life Assurance Company of Canada (Underwritten by Union Security Insurance Co)	A+	XV	www.sunlife.com	Yes
United Concordia Companies, Inc.	A	IX	www.unitedconcordia.com	Yes
United Healthcare Insurance Company (Insurance Paper)	A	XV	www.uhc.com	Yes
United Healthcare of Florida, Inc. (HMO Paper)	A	XV	www.uhc.com	Yes

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Marketing Summary

Medical	
Aetna	See Proposal
BlueCross BlueShield	See Proposal
Cigna	Current Carrier- See Proposal
Humana	DTQ- Not Competitive
Maestro Health	See Proposal
PCG Health	See Proposal
United HealthCare	See Proposal

Dental	
Aetna	See Proposal
BlueCross BlueShield	See Proposal
Cigna	Current Carrier- See Proposal
Delta Dental	No Response
Guardian	See Proposal
Humana	See Proposal
Lincoln	See Proposal
MetLife	See Proposal
Mutual of Omaha	DTQ- Not Competitive
Principal	DTQ- Not Competitive
Solstice	Proposal Received, but not A Rated. City received email copy of proposal.
Standard	See Proposal
SunLife	See Proposal
United HealthCare	See Proposal
United Concordia	See Proposal

FSA / RRA	
Aetna	See Proposal
BlueCross BlueShield	See Proposal
Cigna	See Proposal
EBC Flex	See Proposal
HSA Bank	DTQ- Due to size
Infinisource	See Proposal
ProBenefits	See Proposal
TASC	See Proposal
Wageworks	See Proposal

PBM	
Aetna	See Proposal
Axia Strategies	See Proposal
BlueCross BlueShield	See Proposal
Cigna	See Proposal
RxBenefits	See Proposal
UHC	See Proposal
WellDyneRx	See Proposal

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Executive Summary of Self-Funded Administration Fees

Client Name

January 1, 2020 - December 31, 2020

Administrative Fees

Enrollment
Single: 701
Family: 485
Total: 1186

	Current - Cigna	Renewal - Cigna	Proposal - Aetna	Proposal - Florida Blue
Contract Period:				
Rate Guarantee				
TPA:				
Plan Administration Cost:				
Medical Administration	$34.18	$34.18	$28.08	$50.15
Rx Administration	Included	Included (ASO Fee $49.18 if Carve Out)	Included	Included
COBRA Administration	Included	Included	Payflex $0.50pepm + $500 Implementation Fee (Waived if FSA Bundled) + $250 Annual Fee	$1.25
Rate Guarantee	N/A	3 Years, 3% Cap Y4 and Y5	3 Years	2 Years; $51.65 Y3&4, $53.15 Y5
Fee Holiday Terms	N/A	3 Months Y1, 1 Month Y2	2 Months	N/A
Fee Holiday Y1 Total	$43,937.00	$121,612.44	$66,605.76	N/A
Run-out Fees	4 months of ASO fees	4 months of ASO fees	None	3 Months of ASO Fees
Network Access Fee	Included	Included		See Schedule in Proposal
File Feeds to Marathon Health	Included	Included	Included	Additional Fees
Utilization Review	Included	Included	Included	Included
Third Party Stop Loss Fee	N/A		Included	$0.45
Rx Carve Out Fee	N/A	$15.00	Not Available with Carve Out Rx	$4.00
Disease Management	Included	Included	Included	Included
Large Case Management	Included	Included	Included	Included
Transplant Coordination	Included	Included	Included	Included
National Advantage Program w/Medicare Fee Schedule	Included	Included	50% of Savings Retained	Included
Itemized Bill Review	TBD	TBD	50% of Savings Retained	No Charge
Third Party Claim & Code Review Program	TBD	TBD	37.5% of Savings Retained	No Charge
Second Opinion	TBD	TBD	$1 pm Activation Fee; $2,500 per Consult	Best Doctors Second Opinion- $2.48 pepm; requires Teladoc
Standard Facility Charge Review	29% of recoveries	29% of recoveries	50% of Savings Retained	No Charge
Subrogation Recovery	29% of recoveries	29% of recoveries	37.5% of Savings Retained	30% of recoveries
Claims Fiduciary Fee	TBD	TBD	Included	$1.25 pemp
Telemedicine	MD Live & AmWell	MD Live & AmWell	Teladoc	Teladoc
General Medicine Admin Fee	Included	Included	$0.25 pmpm	$0.90
Behavioral Health Admin Fee	N/A	N/A	$0.07 pmpm (Optional and not included in monthly fee below)	N/A
Dermatology Admin Fee	N/A	N/A	$0.25 pmpm (Optional and not included in monthly fee below)	N/A
Per Consultation Admin Fee	N/A	N/A	$3.00	Claims Costs Apply
Wellness	Your Health First	Your Health First (See Questionnaire)	Simple Steps to a Healthy Life (See Questionnaire)	Rally $2.25 pepm
Monthly Cost per Employee:	$34.18	$34.18	$28.83	$51.40
Annual Administration Cost:	$486,449.76	$486,449.76	$410,308.56	$731,524.80
HRA Administration	$1.44	$1.44	$2.75	$4.75
# HRA Enrollees 2019	698	698	698	698
HRA Debit Card	$0.50	$0.50		
Annual HRA Cost	$16,249.44	$16,249.44	$23,034.00	$39,786.00
Annual Administration Including HRA:	$502,699.20	$502,699.20	$433,342.56	$771,310.80
Difference from Current:		$0.00	($69,356.64)	$268,611.60
1st Year Administration Including HRA & Fee Holiday:	$458,762.20	$381,086.76	$366,736.80	$772,008.80
Difference from Current:		($77,675.44)	($92,025.40)	$313,246.60
Allowances:				
Implementation/Communication Allowance		N/A	$30,000.00	$50,000.00
Online Enrollment Fund (Annual)		$40,000.00	-	
Misc (RDS Reporting, CSN, Data Feeds, COBRA)		$11,000.00	See Response to Questions	
AdHoc Reporting Fund		$10,000.00	1st 5 hours Free; No Public Entity Has Used More than 5 Hours	
Annual Wellness Allowance		$60,000.00	$60,000.00	$100,000 Y1, $50,000 Y2+
Annual Well Worker Award			$5,000.00	
Additional:				
Network	Open Access Plus	Open Access Plus	OAPOS; OAMC +65 Retirees	Select (AltNet) FL; PPO Other States
PBM	Cigna/Express Scripts	Cigna/Express Scripts	Aetna	
Rx rebates - % to client		100%	$130/brand ; $433.50/brand MO; See Schedule for Hep C and Y2 & Y3 (Estimated $2,000,000 over 3 Years)	$130/brand; $335/brand 90 Retail/ $375/brand MO/ $1,130/specialty; See Schedule
90 Day Rx at Retail	Included (CVS)	Included (CVS)	-	
Data or Reporting Charge		AdHoc after $10,000 fund is $300/hour; $175 Additional Hours	1st 5 hours Free; $200/hour after 1st 5 hours; No Public Entity Has Used More than 5 Hours	AdHoc $125/hour after 5/quarter for Free
Performance Guarantees:		$60,004 Service PG	50% of Fees	
Service Notes:		Public Sector Service Specialists 24/7 Live Customer Support One Guide Concierge Service ($3.50 pepm)	Dedicated Public Sector Account Team Net Effective Trend Guarantee 3.5% Customer Service M-F 8:00 to 6:00 Concierge Level Member Service	

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Executive Summary of Self-Funded Administration Fees

Client Name

January 1, 2020 - December 31, 2020

Administrative Fees

Enrollment
Single: 701
Family: 485
Total: 1186

	Current - Cigna	Proposal - Maestro Health **Reference Based Pricing**	Proposal - PCG	Proposal - United Healthcare
Contract Period:				
Rate Guarantee				
TPA:				
Plan Administration Cost:				
Medical Administration	$34.18	$15.00	$32.38	$29.00
Reference Based Pricing Repricing Facility Claims	N/A	$16.00	N/A	N/A
Rx Administration	Included	Included	Included	Included
COBRA Administration	Included	Included	Included	0.55 pepm
Rate Guarantee	N/A	3 Years	3 Years	3 Years; +3% Y4; +3% Y5
Fee Holiday	$43,937.00	N/A	N/A	N/A
Run-out Fees	4 months of ASO fees	4 Months of ASO Fees	TBD	2 Months of ASO Fees
Network Access Fee	Included	$4.50		Included
File Feeds to Marathon Health	Included	Included	Included	Included (Standard Medical, Rx, & Eligibility)
Utilization Review	Included	Included		Included
Third Party Stop Loss Fee	N/A	N/A	N/A	$1 pepm
Rx Carve Out Fee	N/A	N/A	N/A	Not Available with Carve Out Rx
Disease Management	Included	Included	N/R	Included
Large Case Management	Included	Included	N/R	Included (See Schedule)
Transplant Coordination	Included	Included	N/R	Included
National Advantage Program w/Medicare Fee Schedule	TBD	Included	N/R	N/A
Itemized Bill Review	TBD	Included	N/R	31% of Savings Retained
Third Party Claim & Code Review Program	TBD	Included	N/R	N/A
Second Opinion	TBD	Included	N/R	N/A
Standard Facility Charge Review	29% of recoveries	Included	N/R	24% of Savings Retained
Subrogation Recovery	29% of recoveries	25% of Savings Retained	N/R	33.33% of Savings Retained
Claims Fiduciary Fee	TBD	1.00 pepm	N/R	$1 pepm if Elected
Shared Savings	29% of Savings Retained	Included	N/R	35% of Savings Retained
Telemedicine	MD Live & AmWell	Teladoc	N/R	
General Medicine Admin Fee	Included	2.75 pepm	N/R	$0.00
Behavioral Health Admin Fee	N/A	Included	N/R	$0.00
Dermatology Admin Fee	N/A	Included	N/R	$0.00
Per Consultation Admin Fee	N/A	TBD	N/R	$0.00
Wellness	Your Health First	HealthyMe (See Proposal)	N/R	Comprehensive Program Rally & Real Appeal(See Proposal)
Monthly Cost per Employee:	$34.18	$35.50	$32.38	$29.55
Annual Administration Cost:	$486,449.76	$505,236.00	$460,832.16	$420,555.60
HRA Administration	$1.44	$4.00		Included in Medical
# HRA Enrollees 2019	698	698	698	698
HRA Debit Card	$0.50		N/R	$0.50
Annual HRA Cost	$16,249.44	$33,504.00	N/R	$4,188.00
Annual Administration Including HRA:	$502,699.20	$538,740.00	$460,832.16	$424,743.60
Difference from Current:	N/A	$36,040.80	($41,867.04)	($77,955.60)
1st Year Administration Including HRA & Fee Holiday:	$458,762.20	$538,740.00	$460,832.16	$424,743.60
Difference from Current:		$79,977.80	$2,069.96	($34,018.60)
Allowances:				
Implementation/Communication Allowance		TBD	$40,000.00	$50,000.00
Online Enrollment Fund (Annual)				
Misc (RDS Reporting, CSN, Data Feeds, COBRA				TBD
AdHoc Reporting Fund				
Annual Wellness Allowance		$0.00	$50,000.00	$50,000.00
Annual Well Worker Award	-	-	-	-
Additional:				
Network	Open Access Plus	PHCS Non Facility Claims	Cigna (??)	UHC Choice Plus POS (Also, Premium Designation Physicians)
PBM	Cigna/Express Scripts	Southern Scripts	Citizens Rx	Optum
Rx rebates - % to client		100% Transparent Model		
Data or Reporting Charge	Included	Included		$23,000 + $0.35pepy for Expanded Reporting AdHoc Reports Additional Fees
Performance Guarantees :		See TPA Fee Schedule	Public Sector Focus, State of FL Vendor	
		Claims Data Savings Analysis $3,000,000+ in Claims Savings Per Year (34%)		
Service Notes:		Customer Service M-F 8:00 to 6:00 $250 per SBC		

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Executive Summary of Medical & Prescription Drug Coverage

Client Name

January 1, 2020 - December 31, 2020

	Aetna- Actives & Pre-65 Retirees				Aetna- Over 65 Retirees			
Vendor								
Plan Name	OAMC $750- Actives & Pre-65 Retirees		OAMC $2,500- Actives & Pre-65 Retirees		OAMC $750- Over 65 Retirees		OAMC $2,500- Over 65 Retirees	
Plan Type	POS		POS		POS		POS	
Plan Details	***Network***		***Network***		***Network***		***Network***	
	Single	***Family***	***Single***	***Family***	***Single***	***Family***	***Single***	***Family***
Plan Deductible:	$750	$2,250	$2,500	$5,000	$750	$2,250	$2,500	$5,000
Embedded Deductible:	Yes		Yes		Yes		Yes	
Calendar or Policy Year:	Calendar		Calendar		Calendar		Calendar	
Coinsurance:	20%		20%		20%		20%	
Maximum Out-of-Pocket:	$2,500	$7,500	$6,500	$10,500	$2,500	$7,500	$6,500	$10,500
(Includes Deductible, Copay, Rx)	Yes		Yes- Includes Rx		Yes		Yes- Includes Rx	
Physician Services								
Office Visit:	$20		$20		$20		$20	
Specialist:	$35		$35		$35		$35	
Chiropractic:	$35		$35		$35		$35	
Telemedicine:	$20		$20		$20		$20	
Hospital / Emergency Services								
Inpatient Hospital Per Admission:	Deductible + Coinsurance		Deductible + Coinsurance		Deductible + Coinsurance		Deductible + Coinsurance	
Emergency Room:	$250		$250		$250		$250	
Urgent Care:	$75		$75		$75		$75	
Outpatient Surgical Facility:	Deductible + Coinsurance		Deductible + Coinsurance		Deductible + Coinsurance		Deductible + Coinsurance	
Ambulatory Surgery Center:	Deductible + Coinsurance		Deductible + Coinsurance		Deductible + Coinsurance		Deductible + Coinsurance	
Diagnostic Services								
Lab & X-Ray Outpatient:	$10		$0		$10		$0	
Advanced Imaging Services (MRI, MRA, PET, CT):	$250		Deductible + Coinsurance		$250		Deductible + Coinsurance	
Prescription Drug								
Deductible:	N/A		N/A		N/A		N/A	
Prescription Maximum Out-of-Pocket:	$4,100	$5,700	N/A		$4,100	$5,700	N/A	
Prescription Tier	$5 | $40% of Cost, $35 min.- $75 max. |		$5 | $35 | $70 | $250		$5 | $40% of Cost, $35 min.- $75		$5 | $35 | $70 | $250	
Mail Order Prescription (90 Day Supply):	2.5x Retail Copay		2.5x Retail Copay		2.5x Retail Copay		2.5x Retail Copay	
Non-Network Plan Details	***Non-Network***		***Non-Network***		***Non-Network***		***Non-Network***	
Plan Deductible:	$1,500	$4,500	$5,000	$10,000	$1,500	$4,500	$5,000	$10,000
Coinsurance:	40%		40%		40%		40%	
Maximum Out-of-Pocket:	$90,000	$90,000	$90,000	$90,000	$90,000	$90,000	$90,000	$90,000
Per Occurrence Deductible (Inpatient/Outpatient):	N/A		N/A		N/A		N/A	

Plan Rates | Current Enrollment	Aetna- Actives & Pre-65 Retirees				Aetna- Over 65 Retirees			
Employee:	285	$862.22	197	$751.85	122	$760.47	97	$663.13
Employee + One:	122	$2,015.85	73	$1,757.82	60	$1,777.98	19	$1,550.39
Employee + Family:	160	$2,762.38	50	$2,408.79	0	$2,436.42	1	$2,124.55
Estimated Monthly Premiums:	567	$933,647	320	$396,875	182	$199,456	117	$95,906
Estimated Annual Premiums:		**$11,203,766**		**$4,762,498**		**$2,393,474**		**$1,150,867**

	Aetna- Actives & Pre-65 Retirees	Aetna- Over 65 Retirees
Estimated Grand Total Annual Premiums:	**$15,966,264**	**$3,544,341**

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Executive Summary of Medical & Prescription Drug Coverage

Client Name

January 1, 2020 - December 31, 2020

Plan Design Comparison for Self Funded Proposal

	Current - Cigna						Proposed - Aetna			
Vendor										
Plan Name	Open Access Plan (OAP)			Consumer Driven Health Plan (CDHP)			ASC POSII (OAPC)		ASC POSII (OAHD)	
Plan Type	POS			POS			POS		POS	
Plan Details	***Network***			***Network***			***Network***		***Network***	
	Single	***Individual + 1***	***Family***	***Single***	***Individual + 1***	***Family***	***Single***	***Family***	***Single***	***Family***
Plan Deductible:	$750	$1,500	$2,250	$2,500	$5,000	$7,500	$750	$2,250	$2,500	$5,000
Embedded Deductible:		Yes			Yes			Yes		Yes
Calendar or Policy Year:		Calendar			Calendar			Calendar		Calendar
Coinsurance:		20%			20%			20%		20%
Maximum Out-of-Pocket:	$2,500	$5,000	$7,500	$6,500	$10,500	$13,200	$2,500	$7,500	$6,500	$10,500
(Includes Deductible, Copay)		Yes			Yes- Includes Rx			Yes		Yes- Includes Rx
Physician Services										
Office Visit:		$20			$20			$20		$20
		$35 CCN Specialist | $50 Non-CCN			$35 CCN Specialist | $50 Non-CCN					
Specialist:		Specialist			Specialist			$35		$35
Chiropractic:		$50			$50			$35		$35
Telemedicine:		$20			$20			$20		$20
Hospital / Emergency Services										
Inpatient Hospital Per Admission:		Deductible + Coinsurance			Deductible + Coinsurance			Deductible + Coinsurance		Deductible + Coinsurance
Emergency Room:		$250			$250			$250		$250
Urgent Care:		$75			$75			$75		$75
Outpatient Surgical Facility:		Deductible + Coinsurance			Deductible + Coinsurance			Deductible + Coinsurance		Deductible + Coinsurance
Ambulatory Surgery Center:		Deductible + Coinsurance			Deductible + Coinsurance			Deductible + Coinsurance		Deductible + Coinsurance
Diagnostic Services										
Lab & X-Ray Outpatient:		$10			Deductible + Coinsurance			$10		$0
Advanced Imaging Services (MRI, MRA, PET, CT):		$250			Deductible + Coinsurance			$250		Deductible + Coinsurance
Prescription Drug										
Deductible:		N/A			N/A			N/A		N/A
Prescription Maximum Out-of-Pocket:	$4,100	$5,700	$5,700		N/A		$4,100	$5,700		N/A
Prescription Tier		$5 | $40% of Cost, $35 min.- $75 max. | 60% of Cost, $70 min.- $100 max | $250			$5 | $35 | $70 | $250			$5 | $40% of Cost, $35 min.- $75 max. | 60% of Cost, $70 min.- $100 max | $250		$5 | $35 | $70 | $250
Mail Order Prescription (90 Day Supply):		2.5x Retail Copay			2.5x Retail Copay			2.5x Retail Copay		2.5x Retail Copay
Non-Network Plan Details		***Non-Network***			***Non-Network***			***Non-Network***		***Non-Network***
Plan Deductible:	$1,500	$3,000	$4,500	$5,000	$10,000	$15,000	$1,500	$4,500	$5,000	$10,000
Coinsurance:		40%			40%			40%		40%
Maximum Out-of-Pocket:	$90,000	$90,000	$90,000	$90,000	$90,000	$90,000	$90,000	$90,000	$90,000	$90,000
Per Occurrence Deductible (Inpatient/Outpatient):		N/A			N/A			N/A		N/A

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Executive Summary of Medical & Prescription Drug Coverage

Client Name
January 1, 2020 - December 31, 2020

Plan Design Comparison for Self Funded Proposal

	Current - Cigna						Proposed - United HealthCare					
Vendor												
Plan Name	Open Access Plan (OAP)			Consumer Driven Health Plan (CDHP)			Choice Plus AQOOMOD			Choice Plus AQORMOD		
Plan Type	POS			POS			POS			POS		
Plan Details	***Network***			***Network***			***Network***			***Network***		
	Single	***Individual + 1***	***Family***	***Single***	***Individual + 1***	***Family***	***Single***	***Individual + 1***	***Family***	***Single***	***Individual + 1***	***Family***
Plan Deductible:	$750	$1,500	$2,250	$2,500	$5,000	$7,500	$750	$1,500	$2,250	$2,500	$5,000	$7,500
Embedded Deductible:		Yes			Yes			Yes			Yes	
Calendar or Policy Year:		Calendar			Calendar			Calendar			Calendar	
Coinsurance:		20%			20%			20%			20%	
Maximum Out-of-Pocket:	$2,500	$5,000	$7,500	$6,500	$10,500	$13,200	$2,500	$5,000	$7,500	$6,500	$10,500	$13,200
(Includes Deductible, Copay)		Yes			Yes- Includes Rx			Yes			Yes- Includes Rx	
Physician Services												
Office Visit:		$20			$20			$20			$20	
Specialist:		$35 CCN Specialist | $50 Non-CCN Specialist			$35 CCN Specialist | $50 Non-CCN Specialist			$35 PD Specialist | $50 Non-PD Specialist			$35 PD Specialist | $50 Non-PD Specialist	
Chiropractic:		$50			$50			$50			$50	
Telemedicine:		$20			$20			$20			$20	
Hospital / Emergency Services												
Inpatient Hospital Per Admission:		Deductible + Coinsurance			Deductible + Coinsurance			Deductible + Coinsurance			Deductible + Coinsurance	
Emergency Room:		$250			$250			$250			$250	
Urgent Care:		$75			$75			$75			$75	
Outpatient Surgical Facility:		Deductible + Coinsurance			Deductible + Coinsurance			Deductible + Coinsurance			Deductible + Coinsurance	
Ambulatory Surgery Center:		Deductible + Coinsurance			Deductible + Coinsurance			Deductible + Coinsurance			Deductible + Coinsurance	
Diagnostic Services												
Lab & X-Ray Outpatient:		$10			Deductible + Coinsurance			$10			Deductible + Coinsurance	
Advanced Imaging Services (MRI, MRA, PET, CT):		$250			Deductible + Coinsurance			$250			Deductible + Coinsurance	
Prescription Drug												
Deductible:		N/A			N/A			N/A			N/A	
Prescription Maximum Out-of-Pocket:	$4,100	$5,700	$5,700		N/A		$4,100	$5,700	$5,700		N/A	
Prescription Tier		$5 | $40% of Cost, $35 min.- $75 max. | 60% of Cost, $70 min.- $100 max | $250			$5 | $35 | $70 | $250			$5 | $40% of Cost, $35 min.- $75 max. | 60% of Cost, $70 min.- $100 max | $250			$5 | $35 | $70 | $250	
Mail Order Prescription (90 Day Supply):		2.5x Retail Copay			2.5x Retail Copay			2.5x Retail Copay			2.5x Retail Copay	
Non-Network Plan Details	***Non-Network***			***Non-Network***			***Non-Network***			***Non-Network***		
Plan Deductible:	$1,500	$3,000	$4,500	$5,000	$10,000	$15,000	$1,500	$3,000	$4,500	$5,000	$10,000	$15,000
Coinsurance:		40%			40%			40%			40%	
Maximum Out-of-Pocket:	$90,000	$90,000	$90,000	$90,000	$90,000	$90,000	$90,000	$90,000	$90,000	$90,000	$90,000	$90,000
Per Occurrence Deductible (Inpatient/Outpatient):		N/A			N/A			N/A			N/A	

Three potential deviations: 1. TMJ – we can administer the benefit as written for surgical services, but are unable to administer the case-by-case review for non-surgical services. 2. Urgent Care – our claim system is unable to determine if the service was emergency or no-emergency. We would suggest differentiation for in and out of network rather than severity. 3. Genetic Testing – our claim system cannot determine if the person has symptoms or signs of a genetically-linked inherited disease. We would suggest removing those parameters for coverage.

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Executive Summary of Self-Funded Dental

Client Name

January 1, 2020 - December 31, 2020

Enrollment 1212

Carrier	ASO Fee	Annual ASO	2018 Claims Cost	Total 2018 Cost	Total Effective Discount	PPO Discount	OON/80th Discount
Cigna Current (Based on 2018 Claims)	2.96	43,050.24	634,656.00	677,706.24	TBD	TBD	TBD
Cigna Renewal (W/Med)	2.96	43,050.24			TBD	TBD	TBD
Aetna	2.70	39,268.80			35%	35%	4%
BCBS/FCL	3.90	56,721.60			29%	44%	7%
Guardian	2.96	43,050.24			29%	25%	12%
Humana	2.86	41,595.84			-	38%	-
MetLife	4.00	58,176.00			34%	41%	5%
Standard	3.51	51,049.44			21%	21%	2%
UHC	2.58	37,523.52			22%	34%	3%
United Concordia	7.00	101,808.00			32%	42%	9%

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Executive Summary of Dental Coverage

Client Name
January 1, 2020 - December 31, 2020

	Current - Cigna				Proposal - Cigna			
Vendor								
Network:	Cigna Dental PPO		Cigna Dental PPO		Cigna Dental PPO		Cigna Dental PPO	
Plan Name:	Dental Base PPO Plan		Dental Buy Up PPO Plan		Dental Base PPO Plan		Dental Buy Up PPO Plan- Alternate	
	Network		Network		Network		Network	
Plan Details	Single	Family	Single	Family	Single	Family	Single	Family
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		100% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Orthodontic Lifetime Maximum:	$1,500		$1,500		$1,500		$1,500	
Included Adult Ortho:	Yes		Yes		Yes		Yes	
Dental Services	Benefit Level	Frequency	Benefit Level	Frequency	Benefit Level	Frequency	Benefit Level	Frequency
Routine Exam & Cleaning:	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year
Fluoride Treatment:	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19
X-Ray (Bitewings):	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year
X-Ray (Full Mouth):	Preventive	1 per 36 months	Preventive	1 per 36 months	Preventive	1 per 36 months	Preventive	1 per 36 months
Sealants:	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14
Fillings:	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Oral Surgery (Simple):	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Oral Surgery (Complex):	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Root Canal Therapy:	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime
Periodontal Scaling:	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service
Periodontal Surgery:	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service
Crowns:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years
Bridges	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years
Dentures:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years
Implants:	Not covered	N/A	Not covered	N/A	Not covered	N/A	Not covered	N/A
Non-Network Details	Non-Network		Non-Network		Non-Network		Non-Network	
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		100% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Percent of UCR:	80th		80th		80th		80th	
Waiting Periods:	None		None		None		None	
Late Entrant Penalties:	None		None		None		None	
Allows Annual Open Enrollment:	Yes		Yes		Yes		Yes	
Included Rollover:	None		None		None		None	
Employer Contribution:	Continuing current contributions		Continuing current contributions		Continuing current contributions		Continuing current contributions	
Participation Requirement:	< 15% variation from current enrollment		< 15% variation from current enrollment		< 15% variation from current enrollment		< 15% variation from current enrollment	
Rate Guarantee:	3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured	

Plan Rates I Current Enrollment		Proposal- Cigna			Proposal - Cigna	
Employee:	504	$31.23	95	$33.39	$31.23	$39.13
Employee + One:	294	$61.20	79	$65.14	$61.20	$76.34
Employee + Family:	182	$121.35	58	$125.98	$121.35	$147.65
Total:	980		232			
Estimated Monthly Premiums:		$55,818		$15,625	$55,818	$18,312
Estimated Annual Premiums:		**$669,821**		**$187,499**	**$669,821**	**$219,743**
Rate Change from Current:						

	Proposal- Cigna	Proposal - Cigna
Estimated Grand Total Annual Premiums:	**$857,320**	**$889,564**

ASO Fees PEPM	Current - Cigna ASO Fees	Renewal - Cigna ASO Fees	Proposal - Cigna ASO Fees
	$2.96	**$2.96 packaged ($3.21 if stand-alone)**	**$2.96 packaged ($3.21 if stand-alone)**

Notes: **Online subsidy credit included in Medical ASO fees.**

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Executive Summary of Dental Coverage

Client Name
January 1, 2020 - December 31, 2020

	Current - Cigna				Proposal - Aetna			
Vendor								
Network:	Cigna Dental PPO		Cigna Dental PPO		Aetna Dental PPO II		Aetna Dental PPO II	
Plan Name:	Dental Base PPO Plan		Dental Buy Up PPO Plan		Low Plan		High Plan	
Plan Details	***Network***		***Network***		***Network***		***Network***	
	Single	***Family***	***Single***	***Family***	***Single***	***Family***	***Single***	***Family***
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Orthodontic Lifetime Maximum:	$1,500		$1,500		$1,500		$1,500	
Included Adult Ortho:	Yes		Yes		Yes		Yes	
Dental Services	***Benefit Level***	***Frequency***	***Benefit Level***	***Frequency***	***Benefit Level***	***Frequency***	***Benefit Level***	***Frequency***
Routine Exam & Cleaning:	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year
Fluoride Treatment:	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19
X-Ray (Bitewings):	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year
X-Ray (Full Mouth):	Preventive	1 per 36 months	Preventive	1 per 36 months	Preventive	1 per 36 months	Preventive	1 per 36 months
Sealants:	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14
Fillings:	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Oral Surgery (Simple):	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Oral Surgery (Complex):	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Root Canal Therapy:	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime
Periodontal Scaling:	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service
Periodontal Surgery:	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service
Crowns:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years
Bridges	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years
Dentures:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years
Implants:	Not covered	N/A	Not covered	N/A	Not covered	N/A	Not covered	N/A
Non-Network Details	***Non-Network***		***Non-Network***		***Non-Network***		***Non-Network***	
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Percent of UCR:	80th		80th		80th		80th	
Waiting Periods:	None		None		None		None	
Late Entrant Penalties:	None		None		None		None	
Allows Annual Open Enrollment:	Yes		Yes		Yes		Yes	
Included Rollover:	None		None		None		None	
Employer Contribution:	Continuing current contributions		Continuing current contributions					
Participation Requirement:	< 15% variation from current enrollment		< 15% variation from current enrollment		Assumes 1,212 employees enrolled		Assumes 1,212 employees enrolled	
Rate Guarantee:	3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years- ASO | 1 Year (5% rate cap on year 2)- Fully Insured		3 Years- ASO | 1 Year (5% rate cap on year 2)- Fully Insured	

Plan Rates I Current Enrollment		Proposal- Cigna		Proposal- Cigna	Proposal - Aetna	Proposal - Aetna
Employee:	504	$31.23	95	$33.39	$33.33	$40.16
Employee + One:	294	$61.20	79	$65.14	$61.91	$74.58
Employee + Family:	182	$121.35	58	$125.98	$90.48	$108.97
Total:	980		232			
Estimated Monthly Premiums:		$55,818		$15,625	$51,467	$16,027
Estimated Annual Premiums:		**$669,821**		**$187,499**	**$617,607**	**$192,327**
Rate Change from Current:						
		Proposal- Cigna			Proposal - Aetna	
Estimated Grand Total Annual Premiums:		**$857,320**			**$809,934**	

ASO Fees PEPM	Current - Cigna ASO Fees	Renewal - Cigna ASO Fees	Proposal - Aetna ASO Fees
	$2.96	**$2.96 packaged ($3.21 if stand-alone)**	**$2.70**

Notes: **Online subsidy credit included in Medical ASO fees.** **Rate assumes medical and dental will be awarded. Aetna is not providing an Online Enrollment subsidy.**

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Executive Summary of Dental Coverage

Client Name
January 1, 2020 - December 31, 2020

	Current - Cigna		Proposal - Aetna	
Vendor				
Network:	Cigna Dental PPO	Cigna Dental PPO	Aetna Dental PPO II	Aetna Dental PPO II
Plan Name:	Dental Base PPO Plan	Dental Buy Up PPO Plan	Low Plan- Option 2	High Plan- Option 2
	Network	***Network***	***Network***	***Network***
Plan Details	***Single*** / ***Family***	***Single*** / ***Family***	***Single*** / ***Family***	***Single*** / ***Family***
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%	80% | 80% | 50% | 50%	100% | 80% | 50% | 50%	100% | 80% | 50% | 50%
Deductible (Family Maximum):	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Deductible Waived for Preventive:	Yes	Yes	Yes	Yes
Calendar Year Maximum:	$1,500	$3,000	$1,500	$3,000
Orthodontic Lifetime Maximum:	$1,500	$1,500	$1,500	$1,500
Included Adult Ortho:	Yes	Yes	Yes	Yes
Dental Services	***Benefit Level*** / ***Frequency***	***Benefit Level*** / ***Frequency***	***Benefit Level*** / ***Frequency***	***Benefit Level*** / ***Frequency***
Routine Exam & Cleaning:	Preventive / 2 per calendar year	Preventive / 2 per calendar year	Preventive / 2 per calendar year	Preventive / 2 per calendar year
Fluoride Treatment:	Preventive / 1 per calendar year, under age 19	Preventive / 1 per calendar year, under age 19	Preventive / 1 per calendar year, under age 19	Preventive / 1 per calendar year, under age 19
X-Ray (Bitewings):	Preventive / 2 per calendar year	Preventive / 2 per calendar year	Preventive / 2 per calendar year	Preventive / 2 per calendar year
X-Ray (Full Mouth):	Preventive / 1 per 36 months	Preventive / 1 per 36 months	Preventive / 1 per 36 months	Preventive / 1 per 36 months
Sealants:	Preventive / 1 treatment per tooth every 36 months, under age 14	Preventive / 1 treatment per tooth every 36 months, under age 14	Preventive / 1 treatment per tooth every 36 months, under age 14	Preventive / 1 treatment per tooth every 36 months, under age 14
Fillings:	Basic / As needed	Basic / As needed	Basic / As needed	Basic / As needed
Oral Surgery (Simple):	Basic / As needed	Basic / As needed	Basic / As needed	Basic / As needed
Oral Surgery (Complex):	Basic / As needed	Basic / As needed	Basic / As needed	Basic / As needed
Root Canal Therapy:	Basic / Once per tooth per lifetime	Basic / Once per tooth per lifetime	Basic / Once per tooth per lifetime	Basic / Once per tooth per lifetime
Periodontal Scaling:	Basic / Depends on the service	Basic / Depends on the service	Basic / Depends on the service	Basic / Depends on the service
Periodontal Surgery:	Basic / Depends on the service	Basic / Depends on the service	Basic / Depends on the service	Basic / Depends on the service
Crowns:	Major / Replacement every 5 years	Major / Replacement every 5 years	Major / Replacement every 5 years	Major / Replacement every 5 years
Bridges	Major / Replacement every 5 years	Major / Replacement every 5 years	Major / Replacement every 5 years	Major / Replacement every 5 years
Dentures:	Major / Replacement every 5 years	Major / Replacement every 5 years	Major / Replacement every 5 years	Major / Replacement every 5 years
Implants:	Not covered / N/A	Not covered / N/A	Not covered / N/A	Not covered / N/A
Non-Network Details	***Non-Network***	***Non-Network***	***Non-Network***	***Non-Network***
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%	80% | 80% | 50% | 50%	100% | 80% | 50% | 50%	100% | 80% | 50% | 50%
Deductible (Family Maximum):	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Deductible Waived for Preventive:	Yes	Yes	Yes	Yes
Calendar Year Maximum:	$1,500	$3,000	$1,500	$3,000
Percent of UCR:	80th	80th	80th	80th
Waiting Periods:	None	None	None	None
Late Entrant Penalties:	None	None	None	None
Allows Annual Open Enrollment:	Yes	Yes	Yes	Yes
Included Rollover:	None	None	None	None
Employer Contribution:	Continuing current contributions	Continuing current contributions		
Participation Requirement:	< 15% variation from current enrollment	< 15% variation from current enrollment	Assumes 1,212 employees enrolled	Assumes 1,212 employees enrolled
Rate Guarantee:	3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured	3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured	3 Years- ASO | 1 Year (5% rate cap on year 2)- Fully Insured	3 Years- ASO | 1 Year (5% rate cap on year 2)- Fully Insured

Plan Rates I Current Enrollment		Proposal- Cigna		Proposal- Cigna	Proposal - Aetna	Proposal - Aetna
Employee:	504	$31.23	95	$33.39	$34.00	$40.96
Employee + One:	294	$61.20	79	$65.14	$63.14	$76.07
Employee + Family:	182	$121.35	58	$125.98	$92.29	$111.15
Total:	980		232			
Estimated Monthly Premiums:		$55,818		$15,625	$52,496	$16,347
Estimated Annual Premiums:		**$669,821**		**$187,499**	**$629,951**	**$196,169**
Rate Change from Current:						
		Proposal- Cigna			Proposal - Aetna	
Estimated Grand Total Annual Premiums:		**$857,320**			**$826,120**	

ASO Fees PEPM	Current - Cigna ASO Fees	Renewal - Cigna ASO Fees	Proposal - Aetna ASO Fees
	$2.96	**$2.96 packaged ($3.21 if stand-alone)**	**$2.70**

Notes: **Online subsidy credit included in Medical ASO fees.** **Rate assumes medical and dental will be awarded. Aetna is not providing an Online Enrollment subsidy.**

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Executive Summary of Dental Coverage

Client Name
January 1, 2020 - December 31, 2020

	Current - Cigna				Proposal - BCBS			
Vendor								
Network:	Cigna Dental PPO		Cigna Dental PPO		BlueDental ChoicePlus		BlueDental ChoicePlus	
Plan Name:	Dental Base PPO Plan		Dental Buy Up PPO Plan		Low Plan		High Plan	
	Network		Network		Network		Network	
Plan Details	Single	Family	Single	Family	Single	Family	Single	Family
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Orthodontic Lifetime Maximum:	$1,500		$1,500		$1,500		$1,500	
Included Adult Ortho:	Yes		Yes		Yes		Yes	
Dental Services	Benefit Level	Frequency	Benefit Level	Frequency	Benefit Level	Frequency	Benefit Level	Frequency
Routine Exam & Cleaning:	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per benefit period	Preventive	2 per benefit period
Fluoride Treatment:	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19	Preventive	2 per benefit period, under age 14	Preventive	2 per benefit period, under age 14
X-Ray (Bitewings):	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	Once per benefit period	Preventive	Once per benefit period
X-Ray (Full Mouth):	Preventive	1 per 36 months	Preventive	1 per 36 months	Preventive	Once in any 36 consecutive month benefit period	Preventive	Once in any 36 consecutive month benefit period
Sealants:	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	Under age 16	Preventive	Under age 16
Fillings:	Basic	As needed	Basic	As needed	Basic	One per tooth per 12 months	Basic	One per tooth per 12 months
Oral Surgery (Simple):	Basic	As needed	Basic	As needed	Basic	Once per lifetime	Basic	Once per lifetime
Oral Surgery (Complex):	Basic	As needed	Basic	As needed	Basic	Once per lifetime	Basic	Once per lifetime
Root Canal Therapy:	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime	Basic	Once per lifetime per tooth	Basic	Once per lifetime per tooth
Periodontal Scaling:	Basic	Depends on the service	Basic	Depends on the service	Basic	Once per quadrant every 24 months, age 18+	Basic	Once per quadrant every 24 months, age 18+
Periodontal Surgery:	Basic	Depends on the service	Basic	Depends on the service	Basic	Once per quadrant per 36 months	Basic	Once per quadrant per 36 months
Crowns:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Once per 60 months	Major	Once per 60 months
Bridges	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	One per 5 years	Major	One per 5 years
Dentures:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	One per 5 years	Major	One per 5 years
Implants:	Not covered	N/A	Not covered	N/A	Major	One per tooth per lifetime, age 16+	Major	One per tooth per lifetime, age 16+
Non-Network Details	Non-Network		Non-Network		Non-Network		Non-Network	
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Percent of UCR:	80th		80th		80th		80th	
Waiting Periods:	None		None		None		None	
Late Entrant Penalties:	None		None		None		None	
Allows Annual Open Enrollment:	Yes		Yes		Yes		Yes	
Included Rollover:	None		None		Yes		Yes	
Employer Contribution:	Continuing current contributions		Continuing current contributions		Continuing current contributions		Continuing current contributions	
Participation Requirement:	< 15% variation from current enrollment		< 15% variation from current enrollment		50%		50%	
Rate Guarantee:	3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years		3 Years	

Plan Rates I Current Enrollment		Proposal- Cigna		Proposal- Cigna	Proposal - BCBS	Proposal - BCBS
Employee:	504	$31.23	95	$33.39	Not Provided	Not Provided
Employee + One:	294	$61.20	79	$65.14	Not Provided	Not Provided
Employee + Family:	182	$121.35	58	$125.98	Not Provided	Not Provided
Total:	980		232			
Estimated Monthly Premiums:		$55,818		$15,625	$0	$0
Estimated Annual Premiums:		**$669,821**		**$187,499**	**$0**	**$0**

	Proposal- Cigna	Proposal - BCBS
Estimated Grand Total Annual Premiums:	**$857,320**	**$0**

ASO Fees PEPM	Current - Cigna ASO Fees	Renewal - Cigna ASO Fees	Proposal - BCBS ASO Fees
	$2.96	**$2.96 packaged ($3.21 if stand-alone)**	**$3.90**

Notes: **Online subsidy credit included in Medical ASO fees.**

ASO fees will remain the same as quoted for the Alternate High Plan Coinsurance 100/80/50/50 both in & out of network. BCBS is not providing an Online Enrollment subsidy.

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Executive Summary of Dental Coverage

Client Name
January 1, 2020 - December 31, 2020

	Current - Cigna				Proposal - Guardian			
Vendor								
Network:	Cigna Dental PPO		Cigna Dental PPO		DentalGuard Preferred		DentalGuard Preferred	
Plan Name:	Dental Base PPO Plan		Dental Buy Up PPO Plan		Low Option		High Option	
	Network		Network		Network		Network	
Plan Details	Single	Family	Single	Family	Single	Family	Single	Family
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Orthodontic Lifetime Maximum:	$1,500		$1,500		$1,500		$1,500	
Included Adult Ortho:	Yes		Yes		Yes		Yes	
Dental Services	Benefit Level	Frequency	Benefit Level	Frequency	Benefit Level	Frequency	Benefit Level	Frequency
Routine Exam & Cleaning:	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year
Fluoride Treatment:	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19
X-Ray (Bitewings):	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year
X-Ray (Full Mouth):	Preventive	1 per 36 months	Preventive	1 per 36 months	Preventive	1 per 36 months	Preventive	1 per 36 months
Sealants:	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14
Fillings:	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Oral Surgery (Simple):	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Oral Surgery (Complex):	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Root Canal Therapy:	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime
Periodontal Scaling:	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service
Periodontal Surgery:	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service
Crowns:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years
Bridges	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years
Dentures:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years
Implants:	Not covered	N/A	Not covered	N/A	Not covered	N/A	Not covered	N/A
Non-Network Details	Non-Network		Non-Network		Non-Network		Non-Network	
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Percent of UCR:	80th		80th		80th		80th	
Waiting Periods:	None		None		None		None	
Late Entrant Penalties:	None		None		None		None	
Allows Annual Open Enrollment:	Yes		Yes		Yes		Yes	
Included Rollover:	None		None		Yes		Yes	
Employer Contribution:	Continuing current contributions		Continuing current contributions		Contributory		Contributory	
Participation Requirement:	< 15% variation from current enrollment		< 15% variation from current enrollment		93%		93%	
Rate Guarantee:	3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years- ASO | 2 Years Fully Insured		3 Years- ASO | 2 Years Fully Insured	

Plan Rates I Current Enrollment		Proposal- Cigna		Proposal- Cigna	Proposal - Guardian	Proposal - Guardian
Employee:	504	$31.23	95	$33.39	$30.30	$37.05
Employee + One:	294	$61.20	79	$65.14	$58.67	$71.21
Employee + Family:	182	$121.35	58	$125.98	$87.04	$105.36
Total:	980		232			
Estimated Monthly Premiums:		$55,818		$15,625	$48,361	$15,256
Estimated Annual Premiums:		**$669,821**		**$187,499**	**$580,338**	**$183,075**

	Proposal- Cigna	Proposal - Guardian
Estimated Grand Total Annual Premiums:	**$857,320**	**$763,412**

ASO Fees PEPM	Current - Cigna ASO Fees	Renewal - Cigna ASO Fees	Proposal - Guardian ASO Fees
	$2.96	**$2.96 packaged ($3.21 if stand-alone)**	**$2.96**

Notes: **Online subsidy credit included in Medical ASO fees.**

Fee would be $2.66 with no implementation credit. College Tuition Benefit: Additional $0.45 pepm. Online Enrollment subsidy: ASO & Fully-Insured Options One- Time Allowance Reimbursement of up to $10,000 or 2% of fully-insured premium (lesser of) for program and transition related expenses.

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Executive Summary of Dental Coverage

Client Name
January 1, 2020 - December 31, 2020

	Current - Cigna				Proposal - Guardian			
Vendor								
Network:	Cigna Dental PPO		Cigna Dental PPO		DentalGuard Preferred		DentalGuard Preferred	
Plan Name:	Dental Base PPO Plan		Dental Buy Up PPO Plan		Low Option		High Option	
	Network		Network		Network		Network	
Plan Details	Single	Family	Single	Family	Single	Family	Single	Family
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		100% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Orthodontic Lifetime Maximum:	$1,500		$1,500		$1,500		$1,500	
Included Adult Ortho:	Yes		Yes		Yes		Yes	
Dental Services	Benefit Level	Frequency	Benefit Level	Frequency	Benefit Level	Frequency	Benefit Level	Frequency
Routine Exam & Cleaning:	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year
Fluoride Treatment:	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19
X-Ray (Bitewings):	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year
X-Ray (Full Mouth):	Preventive	1 per 36 months	Preventive	1 per 36 months	Preventive	1 per 36 months	Preventive	1 per 36 months
Sealants:	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14
Fillings:	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Oral Surgery (Simple):	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Oral Surgery (Complex):	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Root Canal Therapy:	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime
Periodontal Scaling:	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service
Periodontal Surgery:	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service
Crowns:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years
Bridges	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years
Dentures:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years
Implants:	Not covered	N/A	Not covered	N/A	Not covered	N/A	Not covered	N/A
Non-Network Details	Non-Network		Non-Network		Non-Network		Non-Network	
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		100% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Percent of UCR:	80th		80th		80th		80th	
Waiting Periods:	None		None		None		None	
Late Entrant Penalties:	None		None		None		None	
Allows Annual Open Enrollment:	Yes		Yes		Yes		Yes	
Included Rollover:	None		None		Yes		Yes	
Employer Contribution:	Continuing current contributions		Continuing current contributions		Contributory		Contributory	
Participation Requirement:	< 15% variation from current enrollment		< 15% variation from current enrollment		93%		93%	
Rate Guarantee:	3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years- ASO | 2 Years Fully Insured		3 Years- ASO | 2 Years Fully Insured	

Plan Rates I Current Enrollment		Proposal- Cigna		Proposal- Cigna	Proposal - Guardian	Proposal - Guardian
Employee:	504	$31.23	95	$33.39	$30.30	$41.75
Employee + One:	294	$61.20	79	$65.14	$58.67	$80.55
Employee + Family:	182	$121.35	58	$125.98	$87.04	$120.48
Total:	980		232			
Estimated Monthly Premiums:		$55,818		$15,625	$48,361	$17,318
Estimated Annual Premiums:		**$669,821**		**$187,499**	**$580,338**	**$207,810**

	Proposal- Cigna	Proposal - Guardian
Estimated Grand Total Annual Premiums:	**$857,320**	**$788,148**

ASO Fees PEPM	Current - Cigna ASO Fees	Renewal - Cigna ASO Fees	Proposal - Guardian ASO Fees
	$2.96	**$2.96 packaged ($3.21 if stand-alone)**	**$2.96**

Notes: **Online subsidy credit included in Medical ASO fees.**

Fee would be $2.66 with no implementation credit. College Tuition Benefit: Additional $0.45 pepm. Online Enrollment subsidy: ASO & Fully-Insured Options One- Time Allowance Reimbursement of up to $10,000 or 2% of fully-insured premium (lesser of) for program and transition related expenses.

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Executive Summary of Dental Coverage

Client Name
January 1, 2020 - December 31, 2020

	Current - Cigna				Proposal - Humana			
Vendor								
Network:	Cigna Dental PPO		Cigna Dental PPO		HumanaDental PPO		HumanaDental PPO	
Plan Name:	Dental Base PPO Plan		Dental Buy Up PPO Plan		Low Plan		High Plan	
	Network		***Network***		***Network***		***Network***	
Plan Details	***Single***	***Family***	***Single***	***Family***	***Single***	***Family***	***Single***	***Family***
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Orthodontic Lifetime Maximum:	$1,500		$1,500		$1,500		$1,500	
Included Adult Ortho:	Yes		Yes		Yes		Yes	
Dental Services	***Benefit Level***	***Frequency***	***Benefit Level***	***Frequency***	***Benefit Level***	***Frequency***	***Benefit Level***	***Frequency***
Routine Exam & Cleaning:	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per year	Preventive	2 per year
Fluoride Treatment:	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19	Preventive	1 per year, through age 18	Preventive	1 per year, through age 18
X-Ray (Bitewings):	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per year	Preventive	2 per year
X-Ray (Full Mouth):	Preventive	1 per 36 months	Preventive	1 per 36 months	Preventive	One set every 3 years	Preventive	One set every 3 years
Sealants:	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	Through age 13	Preventive	Through age 13
Fillings:	Basic	As needed	Basic	As needed	Basic	1 per tooth every 2 years	Basic	1 per tooth every 2 years
Oral Surgery (Simple):	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Oral Surgery (Complex):	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Root Canal Therapy:	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime	Basic	1 per tooth per lifetime and 1 re-treatment	Basic	1 per tooth per lifetime and 1 re-treatment
Periodontal Scaling:	Basic	Depends on the service	Basic	Depends on the service	Basic	1 per quadrant every 3 years	Basic	1 per quadrant every 3 years
Periodontal Surgery:	Basic	Depends on the service	Basic	Depends on the service	Basic	1 per quadrant every 3 years	Basic	1 per quadrant every 3 years
Crowns:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	1 per tooth every 5 years	Major	1 per tooth every 5 years
Bridges	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	1 per tooth every 5 years	Major	1 per tooth every 5 years
Dentures:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	1 per tooth every 5 years	Major	1 per tooth every 5 years
Implants:	Not covered	N/A	Not covered	N/A	Not covered	N/A	Not covered	N/A
Non-Network Details	***Non-Network***		***Non-Network***		***Non-Network***		***Non-Network***	
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Percent of UCR:	80th		80th		80th		80th	
Waiting Periods:	None		None		None		None	
Late Entrant Penalties:	None		None		None		None	
Allows Annual Open Enrollment:	Yes		Yes		Yes		Yes	
Included Rollover:	None		None		None		None	
Employer Contribution:	Continuing current contributions		Continuing current contributions		Continuing current contributions		Continuing current contributions	
Participation Requirement:	< 15% variation from current enrollment		< 15% variation from current enrollment		Minimum 800 subscribers		Minimum 800 subscribers	
Rate Guarantee:	3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years		3 Years	

Plan Rates I Current Enrollment	Proposal- Cigna				Proposal - Humana	
Employee:	504	$31.23	95	$33.39	Not Provided	Not Provided
Employee + One:	294	$61.20	79	$65.14	Not Provided	Not Provided
Employee + Family:	182	$121.35	58	$125.98	Not Provided	Not Provided
Total:	980		232			
Estimated Monthly Premiums:		$55,818		$15,625	$0	$0
Estimated Annual Premiums:		**$669,821**		**$187,499**	**$0**	**$0**

	Proposal- Cigna	Proposal - Humana
Estimated Grand Total Annual Premiums:	**$857,320**	**$0**

ASO Fees PEPM	Current - Cigna ASO Fees	Renewal - Cigna ASO Fees	Proposal - Humana ASO Fees
	$2.96	**$2.96 packaged ($3.21 if stand-alone)**	**$2.86**

Notes: **Online subsidy credit included in Medical ASO fees.**

ASO fees will remain the same as quoted for the Alternate High Plan Coinsurance 100/80/50/50 both in & out of network. Humana is not providing an Online Enrollment subsidy.

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Executive Summary of Dental Coverage

Client Name
January 1, 2020 - December 31, 2020

	Current - Cigna				Proposal - Lincoln			
Vendor								
Network:	Cigna Dental PPO		Cigna Dental PPO		Lincoln DentalConnect		Lincoln DentalConnect	
Plan Name:	Dental Base PPO Plan		Dental Buy Up PPO Plan		Option 1.00 (Low Plan)		Option 1.01 (High Plan)	
	Network		Network		Network		Network	
Plan Details	Single	Family	Single	Family	Single	Family	Single	Family
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Orthodontic Lifetime Maximum:	$1,500		$1,500		$1,500		$1,500	
Included Adult Ortho:	Yes		Yes		Yes		Yes	
Dental Services	Benefit Level	Frequency	Benefit Level	Frequency	Benefit Level	Frequency	Benefit Level	Frequency
Routine Exam & Cleaning:	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per year	Preventive	2 per year
Fluoride Treatment:	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19	Preventive	1 per year, through age 18	Preventive	1 per year, through age 18
X-Ray (Bitewings):	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	1 set per year	Preventive	1 set per year
X-Ray (Full Mouth):	Preventive	1 per 36 months	Preventive	1 per 36 months	Preventive	1 per 3 years	Preventive	1 per 3 years
Sealants:	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 per 36 months, through age 13	Preventive	1 per 36 months, through age 13
Fillings:	Basic	As needed	Basic	As needed	Basic	1 per 24 months	Basic	1 per 24 months
Oral Surgery (Simple):	Basic	As needed	Basic	As needed	Basic	Evaluated per tooth	Basic	Evaluated per tooth
Oral Surgery (Complex):	Basic	As needed	Basic	As needed	Basic	Evaluated per tooth	Basic	Evaluated per tooth
Root Canal Therapy:	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime	Basic	Evaluated per tooth	Basic	Evaluated per tooth
Periodontal Scaling:	Basic	Depends on the service	Basic	Depends on the service	Basic	1 per 24 months	Basic	1 per 24 months
Periodontal Surgery:	Basic	Depends on the service	Basic	Depends on the service	Basic	1 per 36 months	Basic	1 per 36 months
Crowns:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	1 per 5 years, age 16+	Major	1 per 5 years, age 16+
Bridges	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	1 per 5 years	Major	1 per 5 years
Dentures:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	1 per 5 years	Major	1 per 5 years
Implants:	Not covered	N/A	Not covered	N/A	Major	1 per 5 years, age 16+	Major	1 per 5 years, age 16+
Non-Network Details	Non-Network		Non-Network		Non-Network		Non-Network	
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Percent of UCR:	80th		80th		80th		80th	
Waiting Periods:	None		None		None		None	
Late Entrant Penalties:	None		None		None		None	
Allows Annual Open Enrollment:	Yes		Yes		Yes		Yes	
Included Rollover:	None		None		None		None	
Employer Contribution:	Continuing current contributions		Continuing current contributions		50%		50%	
Participation Requirement:	< 15% variation from current enrollment		< 15% variation from current enrollment		90%		90%	
Rate Guarantee:	3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		1 Year		1 Year	

Plan Rates I Current Enrollment		Proposal- Cigna			Proposal - Lincoln	
Employee:	504	$31.23	95	$33.39	$36.00	$43.35
Employee + One:	294	$61.20	79	$65.14	$66.86	$80.49
Employee + Family:	182	$121.35	58	$125.98	$97.71	$117.64
Total:	980		232			
Estimated Monthly Premiums:		$55,818		$15,625	$55,584	$17,300
Estimated Annual Premiums:		**$669,821**		**$187,499**	**$667,009**	**$207,601**

	Proposal- Cigna	Proposal - Lincoln
Estimated Grand Total Annual Premiums:	**$857,320**	**$874,610**

ASO Fees PEPM	Current - Cigna ASO Fees	Renewal - Cigna ASO Fees	Proposal - Lincoln ASO Fees
	$2.96	**$2.96 packaged ($3.21 if stand-alone)**	**N/A**
Notes:	**Online subsidy credit included in Medical ASO fees.**		**Online Enrollment subsidy: Lincoln will confirm subsidy amounts at finalist stage if chosen.**

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Executive Summary of Dental Coverage

Client Name
January 1, 2020 - December 31, 2020

	Current - Cigna				Proposal - Lincoln			
Vendor								
Network:	Cigna Dental PPO		Cigna Dental PPO		Lincoln DentalConnect		Lincoln DentalConnect	
Plan Name:	Dental Base PPO Plan		Dental Buy Up PPO Plan		Option 1.00 (Low Plan- Alternate Plan Design)		Option 1.02 (High Plan- Alternate Plan Design)	
Plan Details	Network		Network		Network		Network	
	Single	Family	Single	Family	Single	Family	Single	Family
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		100% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Orthodontic Lifetime Maximum:	$1,500		$1,500		$1,500		$1,500	
Included Adult Ortho:	Yes		Yes		Yes		Yes	
Dental Services	Benefit Level	Frequency	Benefit Level	Frequency	Benefit Level	Frequency	Benefit Level	Frequency
Routine Exam & Cleaning:	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per year	Preventive	2 per year
Fluoride Treatment:	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19	Preventive	1 per year, through age 18	Preventive	1 per year, through age 18
X-Ray (Bitewings):	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	1 set per year	Preventive	1 set per year
X-Ray (Full Mouth):	Preventive	1 per 36 months	Preventive	1 per 36 months	Preventive	1 per 3 years	Preventive	1 per 3 years
Sealants:	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 per 36 months, through age 13	Preventive	1 per 36 months, through age 13
Fillings:	Basic	As needed	Basic	As needed	Basic	1 per 24 months	Basic	1 per 24 months
Oral Surgery (Simple):	Basic	As needed	Basic	As needed	Basic	Evaluated per tooth	Basic	Evaluated per tooth
Oral Surgery (Complex):	Basic	As needed	Basic	As needed	Basic	Evaluated per tooth	Basic	Evaluated per tooth
Root Canal Therapy:	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime	Basic	Evaluated per tooth	Basic	Evaluated per tooth
Periodontal Scaling:	Basic	Depends on the service	Basic	Depends on the service	Basic	1 per 24 months	Basic	1 per 24 months
Periodontal Surgery:	Basic	Depends on the service	Basic	Depends on the service	Basic	1 per 36 months	Basic	1 per 36 months
Crowns:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	1 per 5 years, age 16+	Major	1 per 5 years, age 16+
Bridges	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	1 per 5 years	Major	1 per 5 years
Dentures:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	1 per 5 years	Major	1 per 5 years
Implants:	Not covered	N/A	Not covered	N/A	Major	1 per 5 years, age 16+	Major	1 per 5 years, age 16+
Non-Network Details	Non-Network		Non-Network		Non-Network		Non-Network	
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		100% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Percent of UCR:	80th		80th		80th		80th	
Waiting Periods:	None		None		None		None	
Late Entrant Penalties:	None		None		None		None	
Allows Annual Open Enrollment:	Yes		Yes		Yes		Yes	
Included Rollover:	None		None		None		None	
Employer Contribution:	Continuing current contributions		Continuing current contributions		50%		50%	
Participation Requirement:	< 15% variation from current enrollment		< 15% variation from current enrollment		90%		90%	
Rate Guarantee:	3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		1 Year		1 Year	

Plan Rates I Current Enrollment		Proposal- Cigna		Proposal- Cigna	Proposal - Lincoln	Proposal - Lincoln
Employee:	504	$31.23	95	$33.39	$36.00	$51.77
Employee + One:	294	$61.20	79	$65.14	$66.86	$96.14
Employee + Family:	182	$121.35	58	$125.98	$97.71	$140.52
Total:	980		232			
Estimated Monthly Premiums:		$55,818		$15,625	$55,584	$20,663
Estimated Annual Premiums:		**$669,821**		**$187,499**	**$667,009**	**$247,960**

	Proposal- Cigna	Proposal - Lincoln
Estimated Grand Total Annual Premiums:	**$857,320**	**$914,969**

ASO Fees PEPM	Current - Cigna ASO Fees	Renewal - Cigna ASO Fees	Proposal - Lincoln ASO Fees
	$2.96	**$2.96 packaged ($3.21 if stand-alone)**	**N/A**

Notes: **Online subsidy credit included in Medical ASO fees.** **Online Enrollment subsidy: Lincoln will confirm subsidy amounts at finalist stage if chosen.**

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Executive Summary of Dental Coverage

Client Name
January 1, 2020 - December 31, 2020

	Current - Cigna				Proposal - MetLife			
Vendor								
Network:	Cigna Dental PPO		Cigna Dental PPO		PDP Plus		PDP Plus	
Plan Name:	Dental Base PPO Plan		Dental Buy Up PPO Plan		Low Plan		High Plan	
	Network		Network		Network		Network	
Plan Details	Single	Family	Single	Family	Single	Family	Single	Family
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Orthodontic Lifetime Maximum:	$1,500		$1,500		$1,500		$1,500	
Included Adult Ortho:	Yes		Yes		Yes		Yes	
Dental Services	Benefit Level	Frequency	Benefit Level	Frequency	Benefit Level	Frequency	Benefit Level	Frequency
Routine Exam & Cleaning:	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 times in 1 calendar year	Preventive	2 times in 1 calendar year
Fluoride Treatment:	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19	Preventive	1 time in 1 year	Preventive	1 time in 1 year
X-Ray (Bitewings):	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 times in 1 calendar year	Preventive	2 times in 1 calendar year
X-Ray (Full Mouth):	Preventive	1 per 36 months	Preventive	1 per 36 months	Preventive	Once in 36 months	Preventive	Once in 36 months
Sealants:	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 per molar in 36 months	Preventive	1 per molar in 36 months
Fillings:	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Oral Surgery (Simple):	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Oral Surgery (Complex):	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Root Canal Therapy:	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime
Periodontal Scaling:	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service
Periodontal Surgery:	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service
Crowns:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	1 per tooth in 60 months	Major	1 per tooth in 60 months
Bridges	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	1 in 60 months	Major	1 in 60 months
Dentures:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	1 in 60 months	Major	1 in 60 months
Implants:	Not covered	N/A	Not covered	N/A	Not covered	N/A	Not covered	N/A
Non-Network Details	Non-Network		Non-Network		Non-Network		Non-Network	
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Percent of UCR:	80th		80th		80th		80th	
Waiting Periods:	None		None		None		None	
Late Entrant Penalties:	None		None		12 months for all services		12 months for all services	
Allows Annual Open Enrollment:	Yes		Yes		Yes		Yes	
Included Rollover:	None		None		None		None	
Employer Contribution:	Continuing current contributions		Continuing current contributions		Continuing current contributions		Continuing current contributions	
Participation Requirement:	< 15% variation from current enrollment		< 15% variation from current enrollment		93%		93%	
Rate Guarantee:	3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years- ASO | 2 Years (8% rate cap on year 3)- Fully Insured		3 Years- ASO | 2 Years (8% rate cap on year 3)- Fully Insured	

Plan Rates | Current Enrollment	Proposal- Cigna				Proposal - MetLife	
Employee:	504	$31.23	95	$33.39	$32.55	$39.19
Employee + One:	294	$61.20	79	$65.14	$60.45	$72.78
Employee + Family:	182	$121.35	58	$125.98	$91.14	$106.37
Total:	980		232			
Estimated Monthly Premiums:		$55,818		$15,625	$50,765	$15,642
Estimated Annual Premiums:		**$669,821**		**$187,499**	**$609,180**	**$187,706**

	Proposal- Cigna	Proposal - MetLife
Estimated Grand Total Annual Premiums:	**$857,320**	**$796,885**

ASO Fees PEPM	Current - Cigna ASO Fees	Renewal - Cigna ASO Fees	Proposal - MetLife ASO Fees
	$2.96	**$2.96 packaged ($3.21 if stand-alone)**	**$4.00**

Notes: **Online subsidy credit included in Medical ASO fees.**

Online Enrollment subsidy: MetLife will provide 3% of premium on fully-insured coverage with the condition it is one of the many platforms they work with.

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Executive Summary of Dental Coverage

Client Name
January 1, 2020 - December 31, 2020

	Current - Cigna		Proposal - MetLife	
Vendor				
Network:	Cigna Dental PPO	Cigna Dental PPO	PDP Plus	PDP Plus
Plan Name:	Dental Base PPO Plan	Dental Buy Up PPO Plan	Alternate Low Plan	Alternate High Plan
	Network	Network	Network	Network
Plan Details	Single / Family	Single / Family	Single / Family	Single / Family
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%	80% | 80% | 50% | 50%	80% | 80% | 50% | 50%	100% | 80% | 50% | 50%
Deductible (Family Maximum):	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Deductible Waived for Preventive:	Yes	Yes	Yes	Yes
Calendar Year Maximum:	$1,500	$3,000	$1,500	$3,000
Orthodontic Lifetime Maximum:	$1,500	$1,500	$1,500	$1,500
Included Adult Ortho:	Yes	Yes	Yes	Yes
Dental Services	Benefit Level / Frequency	Benefit Level / Frequency	Benefit Level / Frequency	Benefit Level / Frequency
Routine Exam & Cleaning:	Preventive / 2 per calendar year	Preventive / 2 per calendar year	Preventive / 2 times in 1 calendar year	Preventive / 2 times in 1 calendar year
Fluoride Treatment:	Preventive / 1 per calendar year, under age 19	Preventive / 1 per calendar year, under age 19	Preventive / 1 time in 1 year	Preventive / 1 time in 1 year
X-Ray (Bitewings):	Preventive / 2 per calendar year	Preventive / 2 per calendar year	Preventive / 2 times in 1 calendar year	Preventive / 2 times in 1 calendar year
X-Ray (Full Mouth):	Preventive / 1 per 36 months	Preventive / 1 per 36 months	Preventive / Once in 36 months	Preventive / Once in 36 months
Sealants:	Preventive / 1 treatment per tooth every 36 months, under age 14	Preventive / 1 treatment per tooth every 36 months, under age 14	Preventive / 1 per molar in 36 months	Preventive / 1 per molar in 36 months
Fillings:	Basic / As needed	Basic / As needed	Basic / As needed	Basic / As needed
Oral Surgery (Simple):	Basic / As needed	Basic / As needed	Basic / As needed	Basic / As needed
Oral Surgery (Complex):	Basic / As needed	Basic / As needed	Basic / As needed	Basic / As needed
Root Canal Therapy:	Basic / Once per tooth per lifetime	Basic / Once per tooth per lifetime	Basic / Once per tooth per lifetime	Basic / Once per tooth per lifetime
Periodontal Scaling:	Basic / Depends on the service	Basic / Depends on the service	Basic / Depends on the service	Basic / Depends on the service
Periodontal Surgery:	Basic / Depends on the service	Basic / Depends on the service	Basic / Depends on the service	Basic / Depends on the service
Crowns:	Major / Replacement every 5 years	Major / Replacement every 5 years	Major / 1 per tooth in 60 months	Major / 1 per tooth in 60 months
Bridges	Major / Replacement every 5 years	Major / Replacement every 5 years	Major / 1 in 60 months	Major / 1 in 60 months
Dentures:	Major / Replacement every 5 years	Major / Replacement every 5 years	Major / 1 in 60 months	Major / 1 in 60 months
Implants:	Not covered / N/A	Not covered / N/A	Not covered / N/A	Not covered / N/A
Non-Network Details	Non-Network	Non-Network	Non-Network	Non-Network
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%	80% | 80% | 50% | 50%	80% | 80% | 50% | 50%	100% | 80% | 50% | 50%
Deductible (Family Maximum):	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Deductible Waived for Preventive:	Yes	Yes	Yes	Yes
Calendar Year Maximum:	$1,500	$3,000	$1,500	$3,000
Percent of UCR:	80th	80th	80th	80th
Waiting Periods:	None	None	None	None
Late Entrant Penalties:	None	None	12 months for all services	12 months for all services
Allows Annual Open Enrollment:	Yes	Yes	Yes	Yes
Included Rollover:	None	None	None	None
Employer Contribution:	Continuing current contributions	Continuing current contributions	Continuing current contributions	Continuing current contributions
Participation Requirement:	< 15% variation from current enrollment	< 15% variation from current enrollment	93%	93%
Rate Guarantee:	3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured	3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured	3 Years- ASO | 2 Years (8% rate cap on year 3)- Fully Insured	3 Years- ASO | 2 Years (8% rate cap on year 3)- Fully Insured

Plan Rates | Current Enrollment		Proposal- Cigna		Proposal- Cigna	Proposal - MetLife	Proposal - MetLife
Employee:	504	$31.23	95	$33.39	$32.55	$43.89
Employee + One:	294	$61.20	79	$65.14	$60.45	$81.52
Employee + Family:	182	$121.35	58	$125.98	$91.14	$119.14
Total:	980		232			
Estimated Monthly Premiums:		$55,818		$15,625	$50,765	$17,520
Estimated Annual Premiums:		**$669,821**		**$187,499**	**$609,180**	**$210,237**

	Proposal- Cigna	Proposal - MetLife
Estimated Grand Total Annual Premiums:	**$857,320**	**$819,417**

ASO Fees PEPM	Current - Cigna ASO Fees	Renewal - Cigna ASO Fees	Proposal - MetLife ASO Fees
	$2.96	**$2.96 packaged ($3.21 if stand-alone)**	**$4.00**

Notes: **Online subsidy credit included in Medical ASO fees.**

Online Enrollment subsidy: MetLife will provide 3% of premium on fully-insured coverage with the condition it is one of the many platforms they work with.

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Executive Summary of Dental Coverage

Client Name
January 1, 2020 - December 31, 2020

	Current - Cigna				Proposal - Standard			
Vendor								
Network:	Cigna Dental PPO		Cigna Dental PPO		Ameritas		Ameritas	
Plan Name:	Dental Base PPO Plan		Dental Buy Up PPO Plan		Low Plan 1		High Plan 1	
	Network		Network		Network		Network	
Plan Details	Single	Family	Single	Family	Single	Family	Single	Family
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Orthodontic Lifetime Maximum:	$1,500		$1,500		$1,500		$1,500	
Included Adult Ortho:	Yes		Yes		Yes		Yes	
Dental Services	Benefit Level	Frequency	Benefit Level	Frequency	Benefit Level	Frequency	Benefit Level	Frequency
Routine Exam & Cleaning:	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per benefit period	Preventive	2 per benefit period
Fluoride Treatment:	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19	Preventive	1 per benefit period, age 18 & under	Preventive	1 per benefit period, age 18 & under
X-Ray (Bitewings):	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per benefit period	Preventive	2 per benefit period
X-Ray (Full Mouth):	Preventive	1 per 36 months	Preventive	1 per 36 months	Preventive	1 in 3 years	Preventive	1 in 3 years
Sealants:	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	Age 13 & under	Preventive	Age 13 & under
Fillings:	Basic	As needed	Basic	As needed	Basic	1 per 6 months	Basic	1 per 6 months
Oral Surgery (Simple):	Basic	As needed	Basic	As needed	Basic	Several procedures available- limited to any 5 of these procedures per lifetime	Basic	Several procedures available- limited to any 5 of these procedures per lifetime
Oral Surgery (Complex):	Basic	As needed	Basic	As needed	Basic	Several procedures available- limited to any 5 of these procedures per lifetime	Basic	Several procedures available- limited to any 5 of these procedures per lifetime
Root Canal Therapy:	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime	Basic	1 per 12 months	Basic	1 per 12 months
Periodontal Scaling:	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service
Periodontal Surgery:	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service
Crowns:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	1 in 5 years per tooth	Major	1 in 5 years per tooth
Bridges	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	1 in 5 years	Major	1 in 5 years
Dentures:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	1 in 5 years	Major	1 in 5 years
Implants:	Not covered	N/A	Not covered	N/A	Not covered	N/A	Not covered	N/A
Non-Network Details	Non-Network		Non-Network		Non-Network		Non-Network	
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Percent of UCR:	80th		80th		80th		80th	
Waiting Periods:	None		None		None		None	
Late Entrant Penalties:	None		None		None		None	
Allows Annual Open Enrollment:	Yes		Yes		Yes		Yes	
Included Rollover:	None		None		Yes		Yes	
Employer Contribution:	Continuing current contributions		Continuing current contributions		Continuing current contributions		Continuing current contributions	
Participation Requirement:	< 15% variation from current enrollment		< 15% variation from current enrollment		60%		60%	
Rate Guarantee:	3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years- ASO | 2 Years (8% rate cap on 3rd year)- Fully Insured		3 Years- ASO | 2 Years (8% rate cap on 3rd year)- Fully Insured	

Plan Rates I Current Enrollment		Proposal- Cigna			Proposal - Standard	
Employee:	504	$31.23	95	$33.39	$36.59	$44.05
Employee + One:	294	$61.20	79	$65.14	$67.95	$81.81
Employee + Family:	182	$121.35	58	$125.98	$99.32	$119.57
Total:	980		232			
Estimated Monthly Premiums:		$55,818		$15,625	$56,495	$17,583
Estimated Annual Premiums:		**$669,821**		**$187,499**	**$677,939**	**$210,994**

	Proposal- Cigna	Proposal - Standard
Estimated Grand Total Annual Premiums:	**$857,320**	**$888,932**

ASO Fees PEPM	Current - Cigna ASO Fees	Renewal - Cigna ASO Fees	Proposal - Standard ASO Fees
	$2.96	**$2.96 packaged ($3.21 if stand-alone)**	**$3.51**

Notes:

Online subsidy credit included in Medical ASO fees.

PolicyLink Dental + Vision: Members can use up to $150 of their annual dental plan maximum towards vision benefits at the provider of their choice. (Vision must be placed with a carrier that is not The Standard.)
Online Enrollment subsidy: Standard will provide 1% of the fully insured premium.

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Executive Summary of Dental Coverage

Client Name
January 1, 2020 - December 31, 2020

	Current - Cigna				Proposal - Standard			
Vendor								
Network:	Cigna Dental PPO		Cigna Dental PPO		Ameritas		Ameritas	
Plan Name:	Dental Base PPO Plan		Dental Buy Up PPO Plan		Low Plan 2		High Plan 2	
	Network		Network		Network		Network	
Plan Details	Single	Family	Single	Family	Single	Family	Single	Family
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		100% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Orthodontic Lifetime Maximum:	$1,500		$1,500		$1,500		$1,500	
Included Adult Ortho:	Yes		Yes		Yes		Yes	
Dental Services	Benefit Level	Frequency	Benefit Level	Frequency	Benefit Level	Frequency	Benefit Level	Frequency
Routine Exam & Cleaning:	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per benefit period	Preventive	2 per benefit period
Fluoride Treatment:	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19	Preventive	1 per benefit period, age 18 & under	Preventive	1 per benefit period, age 18 & under
X-Ray (Bitewings):	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per benefit period	Preventive	2 per benefit period
X-Ray (Full Mouth):	Preventive	1 per 36 months	Preventive	1 per 36 months	Preventive	1 in 3 years	Preventive	1 in 3 years
Sealants:	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	Age 13 & under	Preventive	Age 13 & under
Fillings:	Basic	As needed	Basic	As needed	Basic	1 per 6 months	Basic	1 per 6 months
Oral Surgery (Simple):	Basic	As needed	Basic	As needed	Basic	Several procedures available- limited to any 5 of these procedures per lifetime	Basic	Several procedures available- limited to any 5 of these procedures per lifetime
Oral Surgery (Complex):	Basic	As needed	Basic	As needed	Basic	Several procedures available- limited to any 5 of these procedures per lifetime	Basic	Several procedures available- limited to any 5 of these procedures per lifetime
Root Canal Therapy:	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime	Basic	1 per 12 months	Basic	1 per 12 months
Periodontal Scaling:	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service
Periodontal Surgery:	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service
Crowns:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	1 in 5 years per tooth	Major	1 in 5 years per tooth
Bridges	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	1 in 5 years	Major	1 in 5 years
Dentures:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	1 in 5 years	Major	1 in 5 years
Implants:	Not covered	N/A	Not covered	N/A	Not covered	N/A	Not covered	N/A
Non-Network Details	Non-Network		Non-Network		Non-Network		Non-Network	
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		100% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Percent of UCR:	80th		80th		80th		80th	
Waiting Periods:	None		None		None		None	
Late Entrant Penalties:	None		None		None		None	
Allows Annual Open Enrollment:	Yes		Yes		Yes		Yes	
Included Rollover:	None		None		Yes		Yes	
Employer Contribution:	Continuing current contributions		Continuing current contributions		Continuing current contributions		Continuing current contributions	
Participation Requirement:	< 15% variation from current enrollment		< 15% variation from current enrollment		60%		60%	
Rate Guarantee:	3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years- ASO | 2 Years (8% rate cap on 3rd year)- Fully Insured		3 Years- ASO | 2 Years (8% rate cap on 3rd year)- Fully Insured	

Plan Rates I Current Enrollment		Proposal- Cigna		Proposal- Cigna	Proposal - Standard	Proposal - Standard
Employee:	504	$31.23	95	$33.39	$36.59	$51.16
Employee + One:	294	$61.20	79	$65.14	$67.95	$95.18
Employee + Family:	182	$121.35	58	$125.98	$99.32	$140.18
Total:	980		232			
Estimated Monthly Premiums:		$55,818		$15,625	$56,495	$20,510
Estimated Annual Premiums:		**$669,821**		**$187,499**	**$677,939**	**$246,118**

	Proposal- Cigna	Proposal - Standard
Estimated Grand Total Annual Premiums:	**$857,320**	**$924,057**

ASO Fees PEPM	Current - Cigna ASO Fees	Renewal - Cigna ASO Fees	Proposal - Standard ASO Fees
	$2.96	**$2.96 packaged ($3.21 if stand-alone)**	**$3.51**

Notes: **Online subsidy credit included in Medical ASO fees.**

PolicyLink Dental + Vision: Members can use up to $150 of their annual dental plan maximum towards vision benefits at the provider of their choice. (Vision must be placed with a carrier that is not The Standard.)
Online Enrollment subsidy: Standard will provide 1% of the fully insured premium.

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Executive Summary of Dental Coverage

Client Name
January 1, 2020 - December 31, 2020

	Current - Cigna				Proposal - Sun Life			
Vendor								
Network:	Cigna Dental PPO		Cigna Dental PPO		Sun Life Dental		Sun Life Dental	
Plan Name:	Dental Base PPO Plan		Dental Buy Up PPO Plan		Basic Plan		Enhanced Plan	
Plan Details	Network Single	Network Family	Network Single	Network Family	Network Single	Network Family	Network Single	Network Family
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Orthodontic Lifetime Maximum:	$1,500		$1,500		$1,500		$1,500	
Included Adult Ortho:	Yes		Yes		Yes		Yes	
Dental Services	Benefit Level	Frequency	Benefit Level	Frequency	Benefit Level	Frequency	Benefit Level	Frequency
Routine Exam & Cleaning:	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year
Fluoride Treatment:	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19	Preventive	1 per 6 months, under age 19	Preventive	1 per 6 months, under age 19
X-Ray (Bitewings):	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year
X-Ray (Full Mouth):	Preventive	1 per 36 months	Preventive	1 per 36 months	Preventive	1 in 36 months	Preventive	1 in 36 months
Sealants:	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	Once per tooth per 36 months, under age 14	Preventive	Once per tooth per 36 months, under age 14
Fillings:	Basic	As needed	Basic	As needed	Basic	Once per tooth surface in 24 months	Basic	Once per tooth surface in 24 months
Oral Surgery (Simple):	Basic	As needed	Basic	As needed	Basic	No limitation	Basic	No limitation
Oral Surgery (Complex):	Basic	As needed	Basic	As needed	Basic	Multiple surgical services on 1 area of the mouth will be based on the most inclusive procedure	Basic	Multiple surgical services on 1 area of the mouth will be based on the most inclusive procedure
Root Canal Therapy:	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime	Basic	1 time per tooth in 24 months	Basic	1 time per tooth in 24 months
Periodontal Scaling:	Basic	Depends on the service	Basic	Depends on the service	Basic	Once per 24 months per area of the mouth	Basic	Once per 24 months per area of the mouth
Periodontal Surgery:	Basic	Depends on the service	Basic	Depends on the service	Basic	Once per 36 months per area of the mouth	Basic	Once per 36 months per area of the mouth
Crowns:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Once per tooth in any 5 years	Major	Once per tooth in any 5 years
Bridges	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Once in any 5 years	Major	Once in any 5 years
Dentures:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Once in any 5 years	Major	Once in any 5 years
Implants:	Not covered	N/A	Not covered	N/A	Not covered	N/A	Not covered	N/A
Non-Network Details	Non-Network		Non-Network		Non-Network		Non-Network	
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Percent of UCR:	80th		80th		45% off the 80th percentile (MAC)		45% off the 80th percentile (MAC)	
Waiting Periods:	None		None		None		None	
Late Entrant Penalties:	None		None		None		None	
Allows Annual Open Enrollment:	Yes		Yes		Yes		Yes	
Included Rollover:	None		None		None		None	
Employer Contribution:	Continuing current contributions		Continuing current contributions		Contributory		Contributory	
Participation Requirement:	< 15% variation from current enrollment		< 15% variation from current enrollment		Assumes 92.9%		Assumes 92.9%	
Rate Guarantee:	3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		2 Years		2 Years	

Plan Rates | Current Enrollment		Proposal- Cigna		Proposal- Cigna	Proposal - Sun Life	Proposal - Sun Life
Employee:	504	$31.23	95	$33.39	$33.96	$40.88
Employee + One:	294	$61.20	79	$65.14	$63.06	$75.93
Employee + Family:	182	$121.35	58	$125.98	$92.17	$110.96
Total:	980		232			
Estimated Monthly Premiums:		$55,818		$15,625	$52,430	$16,318
Estimated Annual Premiums:		**$669,821**		**$187,499**	**$629,165**	**$195,813**

	Proposal- Cigna	Proposal - Sun Life
Estimated Grand Total Annual Premiums:	**$857,320**	**$824,978**

ASO Fees PEPM	Current - Cigna ASO Fees	Renewal - Cigna ASO Fees	Proposal - Standard ASO Fees
	$2.96	**$2.96 packaged ($3.21 if stand-alone)**	**N/A**
Notes:	**Online subsidy credit included in Medical ASO fees.**		**Online Enrollment subsidy: Up to $2.00 pepm**

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Executive Summary of Dental Coverage

Client Name
January 1, 2020 - December 31, 2020

	Current - Cigna		Proposal - Sun Life	
Vendor				
Network:	Cigna Dental PPO	Cigna Dental PPO	Sun Life Dental	Sun Life Dental
Plan Name:	Dental Base PPO Plan	Dental Buy Up PPO Plan	Basic Plan 2	Enhanced Plan 2
	Network	Network	Network	Network
Plan Details	Single / Family	Single / Family	Single / Family	Single / Family
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%	80% | 80% | 50% | 50%	80% | 80% | 50% | 50%	100% | 80% | 50% | 50%
Deductible (Family Maximum):	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Deductible Waived for Preventive:	Yes	Yes	Yes	Yes
Calendar Year Maximum:	$1,500	$3,000	$1,500	$3,000
Orthodontic Lifetime Maximum:	$1,500	$1,500	$1,500	$1,500
Included Adult Ortho:	Yes	Yes	Yes	Yes
Dental Services	Benefit Level / Frequency	Benefit Level / Frequency	Benefit Level / Frequency	Benefit Level / Frequency
Routine Exam & Cleaning:	Preventive / 2 per calendar year	Preventive / 2 per calendar year	Preventive / 2 per calendar year	Preventive / 2 per calendar year
Fluoride Treatment:	Preventive / 1 per calendar year, under age 19	Preventive / 1 per calendar year, under age 19	Preventive / 1 per 6 months, under age 19	Preventive / 1 per 6 months, under age 19
X-Ray (Bitewings):	Preventive / 2 per calendar year	Preventive / 2 per calendar year	Preventive / 2 per calendar year	Preventive / 2 per calendar year
X-Ray (Full Mouth):	Preventive / 1 per 36 months	Preventive / 1 per 36 months	Preventive / 1 in 36 months	Preventive / 1 in 36 months
Sealants:	Preventive / 1 treatment per tooth every 36 months, under age 14	Preventive / 1 treatment per tooth every 36 months, under age 14	Preventive / Once per tooth per 36 months, under age 14	Preventive / Once per tooth per 36 months, under age 14
Fillings:	Basic / As needed	Basic / As needed	Basic / Once per tooth surface in 24 months	Basic / Once per tooth surface in 24 months
Oral Surgery (Simple):	Basic / As needed	Basic / As needed	Basic / No limitation	Basic / No limitation
Oral Surgery (Complex):	Basic / As needed	Basic / As needed	Basic / Multiple surgical services on 1 area of the mouth will be based on the most inclusive procedure	Basic / Multiple surgical services on 1 area of the mouth will be based on the most inclusive procedure
Root Canal Therapy:	Basic / Once per tooth per lifetime	Basic / Once per tooth per lifetime	Basic / 1 time per tooth in 24 months	Basic / 1 time per tooth in 24 months
Periodontal Scaling:	Basic / Depends on the service	Basic / Depends on the service	Basic / Once per 24 months per area of the mouth	Basic / Once per 24 months per area of the mouth
Periodontal Surgery:	Basic / Depends on the service	Basic / Depends on the service	Basic / Once per 36 months per area of the mouth	Basic / Once per 36 months per area of the mouth
Crowns:	Major / Replacement every 5 years	Major / Replacement every 5 years	Major / Once per tooth in any 5 years	Major / Once per tooth in any 5 years
Bridges	Major / Replacement every 5 years	Major / Replacement every 5 years	Major / Once in any 5 years	Major / Once in any 5 years
Dentures:	Major / Replacement every 5 years	Major / Replacement every 5 years	Major / Once in any 5 years	Major / Once in any 5 years
Implants:	Not covered / N/A	Not covered / N/A	Not covered / N/A	Not covered / N/A
Non-Network Details	Non-Network	Non-Network	Non-Network	Non-Network
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%	80% | 80% | 50% | 50%	80% | 80% | 50% | 50%	100% | 80% | 50% | 50%
Deductible (Family Maximum):	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Deductible Waived for Preventive:	Yes	Yes	Yes	Yes
Calendar Year Maximum:	$1,500	$3,000	$1,500	$3,000
Percent of UCR:	80th	80th	45% off the 80th percentile (MAC)	45% off the 80th percentile (MAC)
Waiting Periods:	None	None	None	None
Late Entrant Penalties:	None	None	None	None
Allows Annual Open Enrollment:	Yes	Yes	Yes	Yes
Included Rollover:	None	None	None	None
Employer Contribution:	Continuing current contributions	Continuing current contributions	Contributory	Contributory
Participation Requirement:	< 15% variation from current enrollment	< 15% variation from current enrollment	Assumes 92.9%	Assumes 92.9%
Rate Guarantee:	3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured	3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured	2 Years	2 Years

Plan Rates I Current Enrollment		Proposal- Cigna		Proposal- Cigna	Proposal - Sun Life	Proposal - Sun Life
Employee:	504	$31.23	95	$33.39	$34.56	$41.61
Employee + One:	294	$61.20	79	$65.14	$64.18	$77.27
Employee + Family:	182	$121.35	58	$125.98	$93.80	$112.94
Total:	980		232			
Estimated Monthly Premiums:		$55,818		$15,625	$53,359	$16,608
Estimated Annual Premiums:		**$669,821**		**$187,499**	**$640,305**	**$199,294**

	Proposal- Cigna	Proposal - Sun Life
Estimated Grand Total Annual Premiums:	**$857,320**	**$839,599**

ASO Fees PEPM	Current - Cigna ASO Fees	Renewal - Cigna ASO Fees	Proposal - Standard ASO Fees
	$2.96	**$2.96 packaged ($3.21 if stand-alone)**	**N/A**
Notes:	**Online subsidy credit included in Medical ASO fees.**		**Online Enrollment subsidy: Up to $2.00 pepm**

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Executive Summary of Dental Coverage

Client Name
January 1, 2020 - December 31, 2020

	Current - Cigna		Proposal - United HealthCare	
Vendor				
Network:	Cigna Dental PPO	Cigna Dental PPO	Options PPO 30	Options PPO 30
Plan Name:	Dental Base PPO Plan	Dental Buy Up PPO Plan	Low Option	High Option
	Network	Network	Network	Network
Plan Details	Single / Family	Single / Family	Single / Family	Single / Family
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%	80% | 80% | 50% | 50%	80% | 80% | 50% | 50%	80% | 80% | 50% | 50%
Deductible (Family Maximum):	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Deductible Waived for Preventive:	Yes	Yes	Yes	Yes
Calendar Year Maximum:	$1,500	$3,000	$1,500	$3,000
Orthodontic Lifetime Maximum:	$1,500	$1,500	$1,500	$1,500
Included Adult Ortho:	Yes	Yes	Yes	Yes
Dental Services	Benefit Level / Frequency	Benefit Level / Frequency	Benefit Level / Frequency	Benefit Level / Frequency
Routine Exam & Cleaning:	Preventive / 2 per calendar year	Preventive / 2 per calendar year	Preventive / 2 times per calendar year	Preventive / 2 times per calendar year
	1 per calendar year, under age	1 per calendar year, under age		
Fluoride Treatment:	Preventive / 19	Preventive / 19	Preventive / 2 times per calendar year, under 20 years old	Preventive / 2 times per calendar year, under 20 years old
X-Ray (Bitewings):	Preventive / 2 per calendar year	Preventive / 2 per calendar year	Preventive / 1 series of film per calendar year	Preventive / 1 series of film per calendar year
X-Ray (Full Mouth):	Preventive / 1 per 36 months	Preventive / 1 per 36 months	Preventive / 1 time per 36 months	Preventive / 1 time per 36 months
	1 treatment per tooth every 36	1 treatment per tooth every 36		
Sealants:	Preventive / months, under age 14	Preventive / months, under age 14	Preventive / Once every 36 months, under 20 years old	Preventive / Once every 36 months, under 20 years old
Fillings:	Basic / As needed	Basic / As needed	Basic / As needed	Basic / As needed
Oral Surgery (Simple):	Basic / As needed	Basic / As needed	Basic / As needed	Basic / As needed
Oral Surgery (Complex):	Basic / As needed	Basic / As needed	Basic / As needed	Basic / As needed
Root Canal Therapy:	Basic / Once per tooth per lifetime	Basic / Once per tooth per lifetime	Basic / 1 time per tooth per lifetime	Basic / 1 time per tooth per lifetime
Periodontal Scaling:	Basic / Depends on the service	Basic / Depends on the service	Basic / 1 time per quadrant per 24 months	Basic / 1 time per quadrant per 24 months
			1 quadrant or site per 24 months per	1 quadrant or site per 24 months per
Periodontal Surgery:	Basic / Depends on the service	Basic / Depends on the service	Basic / surgical area	Basic / surgical area
Crowns:	Major / Replacement every 5 years	Major / Replacement every 5 years	Major / 1 time per tooth per 60 months	Major / 1 time per tooth per 60 months
Bridges	Major / Replacement every 5 years	Major / Replacement every 5 years	Major / 1 per 60 months	Major / 1 per 60 months
Dentures:	Major / Replacement every 5 years	Major / Replacement every 5 years	Major / 1 per 60 months	Major / 1 per 60 months
Implants:	Not covered / N/A	Not covered / N/A	Not covered / N/A	Not covered / N/A
Non-Network Details	Non-Network	Non-Network	Non-Network	Non-Network
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%	80% | 80% | 50% | 50%	80% | 80% | 50% | 50%	80% | 80% | 50% | 50%
Deductible (Family Maximum):	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Deductible Waived for Preventive:	Yes	Yes	Yes	Yes
Calendar Year Maximum:	$1,500	$3,000	$1,500	$3,000
Percent of UCR:	80th	80th	80th	80th
Waiting Periods:	None	None	None	None
Late Entrant Penalties:	None	None	None	None
Allows Annual Open Enrollment:	Yes	Yes	Yes	Yes
Included Rollover:	None	None	None	None
Employer Contribution:	Continuing current contributions	Continuing current contributions	Contributory	Contributory
Participation Requirement:	< 15% variation from current enrollment	< 15% variation from current enrollment	75% of eligible employees	75% of eligible employees
Rate Guarantee:	3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured	3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured	3 Years- ASO | 1 Year- Fully Insured	3 Years- ASO | 1 Year- Fully Insured

Plan Rates | Current Enrollment		Proposal- Cigna		Proposal- Cigna	Proposal - United HealthCare	Proposal - United HealthCare
Employee:	504	$31.23	95	$33.39	$35.00	$42.14
Employee + One:	294	$61.20	79	$65.14	$65.00	$78.26
Employee + Family:	182	$121.35	58	$125.98	$95.00	$114.38
Total:	980		232			
Estimated Monthly Premiums:		$55,818		$15,625	$54,040	$16,820
Estimated Annual Premiums:		**$669,821**		**$187,499**	**$648,480**	**$201,839**

	Proposal- Cigna	Proposal - United HealthCare
Estimated Grand Total Annual Premiums:	**$857,320**	**$850,319**

ASO Fees PEPM	Current - Cigna ASO Fees	Renewal - Cigna ASO Fees	Proposal - United HealthCare ASO Fees
	$2.96	**$2.96 packaged ($3.21 if stand-alone)**	**$2.58**

Notes: **Online subsidy credit included in Medical ASO fees.**

Online Enrollment subsidy: Online Onboarding is included in the proposed premiums or fees. No separate additional subsidy is included.

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Executive Summary of Dental Coverage

Client Name
January 1, 2020 - December 31, 2020

	Current - Cigna				Proposal - United HealthCare			
Vendor								
Network:	Cigna Dental PPO		Cigna Dental PPO		Options PPO 30		Options PPO 30	
Plan Name:	Dental Base PPO Plan		Dental Buy Up PPO Plan		Low Option- Alternate		High Option- Alternate	
	Network		Network		Network		Network	
Plan Details	Single	Family	Single	Family	Single	Family	Single	Family
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		100% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Orthodontic Lifetime Maximum:	$1,500		$1,500		$1,500		$1,500	
Included Adult Ortho:	Yes		Yes		Yes		Yes	
Dental Services	Benefit Level	Frequency	Benefit Level	Frequency	Benefit Level	Frequency	Benefit Level	Frequency
Routine Exam & Cleaning:	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 times per calendar year	Preventive	2 times per calendar year
Fluoride Treatment:	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19	Preventive	2 times per calendar year, under 20 years old	Preventive	2 times per calendar year, under 20 years old
X-Ray (Bitewings):	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	1 series of film per calendar year	Preventive	1 series of film per calendar year
X-Ray (Full Mouth):	Preventive	1 per 36 months	Preventive	1 per 36 months	Preventive	1 time per 36 months	Preventive	1 time per 36 months
Sealants:	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	Once every 36 months, under 20 years old	Preventive	Once every 36 months, under 20 years old
Fillings:	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Oral Surgery (Simple):	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Oral Surgery (Complex):	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Root Canal Therapy:	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime	Basic	1 time per tooth per lifetime	Basic	1 time per tooth per lifetime
Periodontal Scaling:	Basic	Depends on the service	Basic	Depends on the service	Basic	1 time per quadrant per 24 months	Basic	1 time per quadrant per 24 months
Periodontal Surgery:	Basic	Depends on the service	Basic	Depends on the service	Basic	1 quadrant or site per 24 months per surgical area	Basic	1 quadrant or site per 24 months per surgical area
Crowns:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	1 time per tooth per 60 months	Major	1 time per tooth per 60 months
Bridges	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	1 per 60 months	Major	1 per 60 months
Dentures:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	1 per 60 months	Major	1 per 60 months
Implants:	Not covered	N/A	Not covered	N/A	Not covered	N/A	Not covered	N/A
Non-Network Details	Non-Network		Non-Network		Non-Network		Non-Network	
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		100% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Percent of UCR:	80th		80th		80th		80th	
Waiting Periods:	None		None		None		None	
Late Entrant Penalties:	None		None		None		None	
Allows Annual Open Enrollment:	Yes		Yes		Yes		Yes	
Included Rollover:	None		None		None		None	
Employer Contribution:	Continuing current contributions		Continuing current contributions		Contributory		Contributory	
Participation Requirement:	< 15% variation from current enrollment		< 15% variation from current enrollment		75% of eligible employees		75% of eligible employees	
Rate Guarantee:	3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years- ASO | 1 Year- Fully Insured		3 Years- ASO | 1 Year- Fully Insured	

Plan Rates I Current Enrollment		Proposal- Cigna		Proposal- Cigna	Proposal - United HealthCare	Proposal - United HealthCare
Employee:	504	$31.23	95	$33.39	$35.00	$46.81
Employee + One:	294	$61.20	79	$65.14	$65.00	$86.93
Employee + Family:	182	$121.35	58	$125.98	$95.00	$127.06
Total:	980		232			
Estimated Monthly Premiums:		$55,818		$15,625	$54,040	$18,684
Estimated Annual Premiums:		**$669,821**		**$187,499**	**$648,480**	**$224,207**

	Proposal- Cigna	Proposal - United HealthCare
Estimated Grand Total Annual Premiums:	**$857,320**	**$872,687**

ASO Fees PEPM	Current - Cigna ASO Fees	Renewal - Cigna ASO Fees	Proposal - United HealthCare ASO Fees
	$2.96	**$2.96 packaged ($3.21 if stand-alone)**	**$2.58**

Notes: **Online subsidy credit included in Medical ASO fees.**

Online Enrollment subsidy: Online Onboarding is included in the proposed premiums or fees. No separate additional subsidy is included.

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Executive Summary of Dental Coverage

Client Name
January 1, 2020 - December 31, 2020

	Current - Cigna				Proposal - United Concordia			
Vendor								
Network:	Cigna Dental PPO		Cigna Dental PPO		Concordia Flex PPO		Concordia Flex PPO	
Plan Name:	Dental Base PPO Plan		Dental Buy Up PPO Plan		Low Option		High Option	
	Network		Network		Network		Network	
Plan Details	Single	Family	Single	Family	Single	Family	Single	Family
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Orthodontic Lifetime Maximum:	$1,500		$1,500		$1,500		$1,500	
Included Adult Ortho:	Yes		Yes		Yes		Yes	
Dental Services	Benefit Level	Frequency	Benefit Level	Frequency	Benefit Level	Frequency	Benefit Level	Frequency
Routine Exam & Cleaning:	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year
Fluoride Treatment:	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19
X-Ray (Bitewings):	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year
X-Ray (Full Mouth):	Preventive	1 per 36 months	Preventive	1 per 36 months	Preventive	1 per 36 months	Preventive	1 per 36 months
Sealants:	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14
Fillings:	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Oral Surgery (Simple):	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Oral Surgery (Complex):	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Root Canal Therapy:	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime
Periodontal Scaling:	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service
Periodontal Surgery:	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service
Crowns:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years
Bridges	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years
Dentures:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years
Implants:	Not covered	N/A	Not covered	N/A	Not covered	N/A	Not covered	N/A
Non-Network Details	Non-Network		Non-Network		Non-Network		Non-Network	
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Percent of UCR:	80th		80th		80th		80th	
Waiting Periods:	None		None		None		None	
Late Entrant Penalties:	None		None		None		None	
Allows Annual Open Enrollment:	Yes		Yes		Yes		Yes	
Included Rollover:	None		None		None		None	
Employer Contribution:	Continuing current contributions		Continuing current contributions		Continuing current contributions		Continuing current contributions	
Participation Requirement:	< 15% variation from current enrollment		< 15% variation from current enrollment		< 15% variation from current enrollment		< 15% variation from current enrollment	
Rate Guarantee:	3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years- ASO | 2 Years (7.5% rate cap on year 3)- Fully Insured		3 Years- ASO | 2 Years (7.5% rate cap on year 3)- Fully Insured	

Plan Rates I Current Enrollment	Proposal- Cigna				Proposal - United Concordia	
Employee:	504	$31.23	95	$33.39	$32.14	$38.70
Employee + One:	294	$61.20	79	$65.14	$59.69	$71.87
Employee + Family:	182	$121.35	58	$125.98	$87.24	$105.04
Total:	980		232			
Estimated Monthly Premiums:		$55,818		$15,625	$49,625	$15,447
Estimated Annual Premiums:		**$669,821**		**$187,499**	**$595,501**	**$185,359**

	Proposal- Cigna	Proposal - United Concordia
Estimated Grand Total Annual Premiums:	**$857,320**	**$780,860**

ASO Fees PEPM	Current - Cigna ASO Fees	Renewal - Cigna ASO Fees	Proposal - United Concordia ASO Fees
	$2.96	**$2.96 packaged ($3.21 if stand-alone)**	**$7.00**

Notes: **Online subsidy credit included in Medical ASO fees.** **Online Enrollment subsidy: One-time implementation credit of $2,500 to be used at their discretion.**

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Executive Summary of Dental Coverage

Client Name
January 1, 2020 - December 31, 2020

	Current - Cigna				Proposal - United Concordia			
Vendor								
Network:	Cigna Dental PPO		Cigna Dental PPO		Concordia Flex PPO		Concordia Flex PPO	
Plan Name:	Dental Base PPO Plan		Dental Buy Up PPO Plan		Alternative Low Plan		Alternative High Plan	
	Network		*Network*		*Network*		*Network*	
Plan Details	***Single***	***Family***	***Single***	***Family***	***Single***	***Family***	***Single***	***Family***
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		100% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Orthodontic Lifetime Maximum:	$1,500		$1,500		$1,500		$1,500	
Included Adult Ortho:	Yes		Yes		Yes		Yes	
Dental Services	***Benefit Level***	***Frequency***	***Benefit Level***	***Frequency***	***Benefit Level***	***Frequency***	***Benefit Level***	***Frequency***
Routine Exam & Cleaning:	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year
Fluoride Treatment:	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19	Preventive	1 per calendar year, under age 19
X-Ray (Bitewings):	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year	Preventive	2 per calendar year
X-Ray (Full Mouth):	Preventive	1 per 36 months	Preventive	1 per 36 months	Preventive	1 per 36 months	Preventive	1 per 36 months
Sealants:	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14	Preventive	1 treatment per tooth every 36 months, under age 14
Fillings:	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Oral Surgery (Simple):	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Oral Surgery (Complex):	Basic	As needed	Basic	As needed	Basic	As needed	Basic	As needed
Root Canal Therapy:	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime	Basic	Once per tooth per lifetime
Periodontal Scaling:	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service
Periodontal Surgery:	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service	Basic	Depends on the service
Crowns:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years
Bridges	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years
Dentures:	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years	Major	Replacement every 5 years
Implants:	Not covered	N/A	Not covered	N/A	Not covered	N/A	Not covered	N/A
Non-Network Details	***Non-Network***		***Non-Network***		***Non-Network***		***Non-Network***	
Coinsurance Percentage (Preventive | Basic | Major | Ortho):	80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		80% | 80% | 50% | 50%		100% | 80% | 50% | 50%	
Deductible (Family Maximum):	$50	$150	$50	$150	$50	$150	$50	$150
Deductible Waived for Preventive:	Yes		Yes		Yes		Yes	
Calendar Year Maximum:	$1,500		$3,000		$1,500		$3,000	
Percent of UCR:	80th		80th		80th		80th	
Waiting Periods:	None		None		None		None	
Late Entrant Penalties:	None		None		None		None	
Allows Annual Open Enrollment:	Yes		Yes		Yes		Yes	
Included Rollover:	None		None		None		None	
Employer Contribution:	Continuing current contributions		Continuing current contributions		Continuing current contributions		Continuing current contributions	
Participation Requirement:	< 15% variation from current enrollment		< 15% variation from current enrollment		< 15% variation from current enrollment		< 15% variation from current enrollment	
Rate Guarantee:	3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years (3% rate cap on years 4 & 5)- ASO | 3 Years (5% rate cap year 4, 6.5% rate cap year 5)- Fully Insured		3 Years- ASO | 2 Years (7.5% rate cap on year 3)- Fully Insured		3 Years- ASO | 2 Years (7.5% rate cap on year 3)- Fully Insured	
Plan Rates | Current Enrollment	Proposal- Cigna				Proposal - United Concordia			
Employee:	504	$31.23	95	$33.39	$32.14		$41.37	
Employee + One:	294	$61.20	79	$65.14	$59.69		$76.82	
Employee + Family:	182	$121.35	58	$125.98	$87.24		$112.28	
Total:	980		232					
Estimated Monthly Premiums:		$55,818		$15,625	$49,625		$16,511	
Estimated Annual Premiums:		**$669,821**		**$187,499**	**$595,501**		**$198,134**	
	Proposal- Cigna				Proposal - United Concordia			
Estimated Grand Total Annual Premiums:	**$857,320**				**$793,635**			
ASO Fees PEPM	Current - Cigna ASO Fees		Renewal - Cigna ASO Fees		Proposal - United Concordia ASO Fees			
	$2.96		**$2.96 packaged ($3.21 if stand-alone)**		**$7.00**			
Notes:	**Online subsidy credit included in Medical ASO fees.**				**Online Enrollment subsidy: One-time implementation credit of $2,500 to be used at their discretion.**			

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Executive Summary of Vision Coverage

Client Name

January 1, 2020 - December 31, 2020

	Current - Envolve	Proposal - Dual Option - Envolve	
Vendor			
Network	Envolve Vision Network	Envolve Vision Network	Envolve Vision Network
Plan Name			
Copays	***Network***	***Network***	***Network***
Exam:	$10	$10	$10
Materials:	$20	$20	$20
Contact Fitting & Follow-up:	Standard: Paid in Full | Specialty : $75 + 20% off balance	Standard: Paid in Full | Specialty : $75 + 20% off balance	Standard: Paid in Full | Specialty : $75 + 20% off balance
Frequencies			
Exams:	12 months	12 months	12 months
Lenses:	12 months (in lieu of contact lenses)	12 months (in lieu of contact lenses)	12 months (in lieu of contact lenses)
Frames:	24 months	24 months	12 months
Contacts:	12 months (in lieu of contact lenses)	12 months (in lieu of contact lenses)	12 months (in lieu of contact lenses)
Allowances			
Frames:	$150 + 20% off balance	$150 + 20% off balance	$150 + 20% off balance
Contact (Elective):	$150 + 20% off balance	$150 + 20% off balance	$150 + 20% off balance
Contact (Medically Necessary):	Paid in Full	Paid iin Full	Paid in Full
Non-Network Allowances	***Non-Network***	***Non-Network***	***Non-Network***
Exam:	38.50	38.50	38.50
Single Vision:	37.50	37.50	37.50
Bifocal:	55	55	55
Trifocal:	90	90	90
Frames:	105	105	105
Contact (Elective):	105	105	105
Contact (Medically Necessary):	210	210	210
Employer Contribution:	0%	0%	0%
Participation Requirement:	50%	50%	50%
Rate Guarantee:	Rate Guarantee until 12/31/2019	Rate Guarantee until 12/31/2019	TBD

Plan Rates | Current Enrollment		Current	Renewal		Proposal - Dual Option - Envolve	
Employee:	361	$4.89	$4.89	361	$4.89	$8.00
Employee + One:	210	$9.28	$9.28	210	$9.28	$15.17
Family:	165	$12.10	$12.10	165	$12.10	$19.80
Total:	736			736		
Estimated Monthly Premiums:		$5,711	$5,711		$5,711	TBD
Estimated Annual Premiums:		**$68,527**	**$68,527**		**$68,527**	**TBD**

Rates are subject to change in July, 2019.

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Executive Summary of Flexible Spending Account Coverage

Client Name

January 1, 2020 - December 31, 2020

	WageWorks- Current | Renewal		WageWorks- Current | Renewa		Aetna		EBC Flex		Infinisource		TASC	
Vendor												
Plan Details	FSA		RRA		FSA	RRA	FSA	RRA	FSA	RRA	FSA	RRA
Initial Set-up Fee:	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Annual Renewal Fee:	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Admin Fee (pepm):	$416.66	$416.66	$4.63	$4.43	$3.00	$4.00	$3.50	$4.50	$3.50	$3.50	$415.66	$4.25
Minimum Monthly Amount:	$416.66	$416.66	$0	$0	$100	$0	$60	$60	$60	$0	$415.66	$0
Rate Guarantee:					3 Years		3 Years		3 Years		3 Years	
Plan Rates	Current	Renewal	Current	Renewal	FSA	RRA	FSA	RRA	FSA	RRA	FSA	RRA
Number of Participants:	147	147	3	3	147	3	147	3	147	3	147	3
Estimated Annual Premiums (First Year):	**$4,999.92**	**$4,999.92**	**$166.68**	**$159.48**	**$5,292**	**$144**	**$6,174**	**$720**	**$6,174**	**$126**	**$4,988**	**$153**
Estimated Annual Premiums:	**$4,999.92**	**$4,999.92**	**$166.68**	**$159.48**	**$5,292**	**$144**	**$6,174**	**$720**	**$6,174**	**$126**	**$4,988**	**$153**
Rate Change from Current (%):		0.0%		-4.3%	5.8%	-13.6%	23.5%	332.0%	23.5%	-24.4%	-0.2%	-8.2%
Rate Change from Current ($):		$0.00		-$7.20	$292.08	-$22.68	$1,174.08	$553.32	$1,174.08	-$40.68	-$12.00	-$13.68

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Executive Summary of Flexible Spending Account Coverage

Client Name

January 1, 2020 - December 31, 2020

	WageWorks- Current | Renewal		WageWorks- Current | Renewa		BCBS		ProBenefits		CIGNA	
Vendor										
Plan Details	FSA		RRA		FSA	RRA	FSA	RRA	FSA	RRA
Initial Set-up Fee:	$0	$0	$0	$0	$0	$0	$500	$500	$0	N/A
Annual Renewal Fee:	$0	$0	$0	$0	$0	$0	$300	$300	$0	N/A
Admin Fee (pepm):	$416.66	$416.66	$4.63	$4.43	$5.50	$3.50	$5.00	$5.00	$4.59	N/A
Minimum Monthly Amount:	$416.66	$416.66	$0	$0	$100	$0	$0	$0	$0	N/A
Rate Guarantee:							3 Years		1 Year	N/A
Plan Rates	Current	Renewal	Current	Renewal	FSA	RRA	FSA	RRA	FSA	RRA
Number of Participants:	147	147	3	3	147	3	147	3	147	N/A
Estimated Annual Premiums (First Year):	**$4,999.92**	**$4,999.92**	**$167**	**$159**	**$9,702**	**$126**	**$9,620**	**$980**	**$8,097**	**N/A**
Estimated Annual Premiums:	**$4,999.92**	**$4,999.92**	**$167**	**$159**	**$9,702**	**$126**	**$9,120**	**$480**	**$8,097**	**N/A**
Rate Change from Current (%):		0.0%		-4.3%	94.0%	-24.4%	92.4%	488.0%	61.9%	N/A
Rate Change from Current ($):		$0.00		-$7.20	$4,702.08	-$40.68	$4,120.08	-$4,519.92	$3,096.84	N/A

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CITY OF GROVELAND

EMPLOYEE BENEFIT GUIDE

April 1, 2019 through March 31, 2020

This Benefit Guide provides a brief description of plan benefits. For more information on plan benefits, exclusions, and limitations, please refer to the Plan documents or contact the carrier/administrator directly. If any conflict arises between this Guide and any plan provisions, the terms of the actual plan document or other applicable documents will govern in all cases. Benefits are subject to modification at any time.

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INTRODUCTION

The City of Groveland is committed to providing our employees with a comprehensive benefits program to help you stay healthy and feel secure. This booklet will describe those benefits which include medical, dental, vision, life/AD&D and voluntary life/AD&D insurance. For a detailed description of these benefits please refer to the applicable Certificates of Coverage.

ELIGIBILITY GUIDELINES

The City's benefit plan year is from April 1st through March 31st. The City provides medical, dental, vision, and basic life insurance to employees that complete the waiting period and meet eligibility requirements. Employees may purchase medical, dental, vision, and voluntary life for themselves and their dependents through payroll deduction.

Employees are eligible to participate in the City's employee benefits program:

- if they work 30 or more hours a week. Coverage will be effective 1st of the month following 30 days of employment.

Dependent Eligibility

A dependent is defined as the participant's legal spouse and dependent child(ren) of the participant. Dependent children may be covered as follows:

- Medical
  - To end of the calendar year following their 26th birthday with no eligibility requirements
  - From their 26th birthday to the end of the calendar year of their 30th birthday if they are unmarried and do not have a dependent of his or her own, is a resident of Florida or a student, and not enrolled in any other health plan
- Dental & Vision
  - To the end of the calendar year following their 26th birthday
- Voluntary Life
  - Unmarried dependent children from 14 days to age 19, or to age 26 if full time student

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MID-YEAR CHANGES

Premiums for medical, dental, and vision insurance are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC) and are pre-tax to the extent permitted. Under Section 125, changes to your pre-tax benefits can be made ONLY during the Open Enrollment period unless you or your qualified dependents experience a qualifying event and the request to make a change is made within 30 days of the qualifying event. An "eligible" qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125.

Qualified Life Events Include but are not limited to:

- You get married or divorced
- You have a child, gain legal custody or adopt a child
- An increase or decrease in your work hours causes eligibility or ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- A child gains or loses coverage with an ex-spouse
- Gain or loss of Medicare coverage
- Losing eligibility for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60-day notification period).

IMPORTANT

If you experience a qualifying event, **you must contact Human Resources within 30 days of the qualifying event** to make the appropriate changes to your coverage. Beyond 30 days, requests will be denied and the employee may be responsible both legally and financially for any claim and/or expense incurred as a result of the employee or a dependent who continues to be enrolled but no longer meets eligibility requirements. If approved, changes will take place on the date of the qualifying event. Any cancellations will be processed on the date that coverage ends. You will be required to furnish valid documentation supporting a change in status or "Qualifying Event." Occurrence of a Qualifying Event during the plan year does not allow for change of Plan type.

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MEDICAL INSURANCE RATES EFFECTIVE APRIL 1, 2019

Plan 1: Copay Plan	
	Employee Pays (Per Payroll Deduction)
Employee Only	$0
Employee + Spouse	$122.46
Employee + Child(ren)	$110.22
Family	$269.41

Plan 2: $1,500 Deductible	
	Employee Pays (Per Payroll Deduction)
Employee Only	$0
Employee + Spouse	$118.88
Employee + Child(ren)	$107.00
Family	$261.54

Plan 3: $500 Deductible	
	Employee Pays (Per Payroll Deduction)
Employee Only	$0
Employee + Spouse	$125.30
Employee + Child(ren)	$112.77
Family	$275.65

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UNITEDHEALTHCARE MEDICAL PLAN 1

Network: Choice Plus
Website: myuhc.com

Benefits	UnitedHealthcare Plan 1	
	PPO Network	Non-Network
Annual Deductible	$0 Individual $0 Family	$5,000 Individual $10,000 Family
Coinsurance	N/A	50%
Annual Out of Pocket Maximum (Includes Deductible & Copays)	$6,500 Individual $13,000 Family	$19,500 Individual $39,000 Family
Preventive Care	$0	Deductible + Coinsurance
Virtual Visit	$0	N/A
Physician Office Visit	$30	Deductible + Coinsurance
Specialist Office Visit	$60	Deductible + Coinsurance
Outpatient Surgery	$1,000	Deductible + Coinsurance
Inpatient Hospitalization	$1,000	Deductible + Coinsurance
Emergency Room (Facility Only)	$500	$500
Urgent Care	$50	Deductible + Coinsurance
Lab	$0	Deductible + Coinsurance
X-Ray	$0	Deductible + Coinsurance
Advanced Imaging	$250	Deductible + Coinsurance
Prescription Drugs Tier 1 Tier 2 Tier 3 Tier 4 Specialty	 $10 Copay $40 Copay $70 Copay 25% Coinsurance 35% Coinsurance	Please see the benefit summary for non-network pharmacy benefits.
Mail Order Prescription Tier 1 Tier 2 Tier 3 Tier 4 Specialty	 $20 Copay $80 Copay $140 Copay 25% Coinsurance Excluded	Please see the benefit summary for non-network pharmacy benefits.
For Limitations & Exclusions, please refer to the certificate of coverage or benefit summary.		

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UNITEDHEALTHCARE MEDICAL PLAN 2

Network: Choice Plus
Website: myuhc.com

Benefits	UnitedHealthcare Plan 2	
	PPO Network	Non-Network
Annual Deductible	$1,500 Individual $3,000 Family	$4,500 Individual $9,000 Family
Coinsurance	20%	50%
Annual Out of Pocket Maximum (Includes Deductible & Copays)	$5,000 Individual $10,000 Family	$15,000 Individual $30,000 Family
Preventive Care	$0	Deductible + Coinsurance
Virtual Visit	$0	N/A
Physician Office Visit	$35	Deductible + Coinsurance
Specialist Office Visit	$45	Deductible + Coinsurance
Outpatient Surgery	Deductible & Coinsurance	Deductible + Coinsurance
Inpatient Hospitalization	Deductible & Coinsurance	Deductible + Coinsurance
Emergency Room (Facility Only)	$350	$350
Urgent Care	$50	Deductible + Coinsurance
Lab	$0	Deductible + Coinsurance
X-Ray	$0	Deductible + Coinsurance
Advanced Imaging	$150	Deductible + Coinsurance
Prescription Drugs Tier 1 Tier 2 Tier 3 Tier 4 Specialty	 $10 copay $45 copay $90 copay 25% Coinsurance 35% Coinsurance	Please see the benefit summary for non-network pharmacy benefits.
Mail Order Prescription Tier 1 Tier 2 Tier 3 Tier 4 Specialty	 $20 copay $90 copay $180 copay 25% Coinsurance Excluded	Please see the benefit summary for non-network pharmacy benefits.
For Limitations & Exclusions, please refer to the certificate of coverage or benefit summary.		

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UNITEDHEALTHCARE MEDICAL PLAN 3

Network: Choice Plus
Website: myuhc.com

Benefits	UnitedHealthcare Plan 3	
	PPO Network	Non-Network
Annual Deductible	$500 Individual $1,000 Family	$1,500 Individual $3,000 Family
Coinsurance	20%	50%
Annual Out of Pocket Maximum (Includes Deductible & Copays)	$4,000 Individual $8,000 Family	$12,000 Individual $24,000 Family
Preventive Care	$0	Deductible & Coinsurance
Virtual Visit	$0	N/A
Physician Office Visit	$25	Deductible & Coinsurance
Specialist Office Visit	$30	Deductible & Coinsurance
Outpatient Surgery	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient Hospitalization	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Room (Facility Only)	$350	$350
Urgent Care	$50	Deductible & Coinsurance
Lab	$0	Deductible & Coinsurance
X-Ray	$0	Deductible & Coinsurance
Advanced Imaging	$150	Deductible & Coinsurance
Prescription Drugs Tier 1 Tier 2 Tier 3 Tier 4 Specialty	 $10 copay $30 copay $50 copay 25% Coinsurance 35% Coinsurance	Please see the benefit summary for non-network pharmacy benefits.
Mail Order Prescription Tier 1 Tier 2 Tier 3 Tier 4 Specialty	 $20 copay $60 copay $100 copay 25% Coinsurance Excluded	Please see the benefit summary for non-network pharmacy benefits.
For Limitations & Exclusions, please refer to the certificate of coverage or benefit summary.		

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UnitedHealthcare
Waiting for Coverage to Start Checklist

Get a head start on getting more out of your health plan.

Even before your health plan ID card arrives and your coverage starts, this checklist can help you get an early jump on taking charge of your health care.

1 Check the mail.

Watch for your ID card to arrive.

2 Go mobile.

Get the **UnitedHealthcare Health4Me®** app so you can get mobile access to health information, a digital ID card, help with finding care and more. Download the app for free today—through the Apple® App Store® or Google Play™ store for Android® devices.

3 Explore your network.

Check who's in the network by using the Find a Doctor directory on **uhc.com** or the **Health4Me** app. You'll also see what clinics and hospitals are in your network.

4 Choose a doctor.

Choose a primary care provider (PCP) so you'll have one main doctor who has an in-depth knowledge of your health. Use the Find a Doctor directory on **uhc.com**, use the **Health4Me** app or call us for help finding a PCP.

5 Set an appointment.

Plan ahead by scheduling an appointment with your PCP before your coverage starts. Just remember that the appointment date must be after your coverage effective date. Many preventive screenings and immunizations are covered at no cost to you, so it's a good idea to get them on the calendar.

6 Bookmark myuhc.com®.

Once you have your ID card, you can activate your online account. Here you can find network doctors, manage costs and see what's covered—all in one spot.

Want to learn more?
Find more resources at **uhc.com/welcome**, including short videos about starting your plan, using your benefits and managing costs.

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UnitedHealthcare

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Providing help and information at your fingertips.

With Care24®, you have access to health and well-being information and support — 7 days a week, 24 hours a day just by calling the toll-free phone number on your health plan ID card. Care24 connects you with registered nurses or counselors who can help you with health concerns, personal or family matters, financial and emotional needs and more.

Nurses at the ready.

Registered nurses are available to help you with questions about health conditions or symptoms and provide information to help you:

- Learn to recognize when self-care, a Virtual Visit, a doctor visit or the emergency room may be appropriate.
- Care24 nurses are here to help you find a doctor or specialist, and check if the doctor is in your network and available. We may even be able to make the appointment for you.
- Understand medication interactions and how to help reduce your prescription costs.

Counselor support.

Counselors are available to help you address a wide range of personal concerns such as emotional distress, relationship worries, anxiety, grief and much more. When you call, you also can connect with legal* and financial professionals.

Local resources.

A Care24 professional may offer to find local, in-person help in some situations. Counselors may also be able to connect you with other helpful resources in your community.

Call Care24 information on:

- Routine illness.
- Minor injuries.
- Stress and anxiety.
- Relationship worries.
- Coping with grief and loss.
- Questions to ask your doctor.
- Personal legal concerns.*
- Men's, women's and children's health.
- Prevention.
- Self-care information.
- Help finding a doctor.
- Information on medications.

Questions or concerns? Contact us today.

You can take advantage of Care24 nurses and counselors by calling the member phone number on your health plan ID card. Or visit myuhc.com® where through Live Nurse Chat you can connect with a registered nurse, 24 hours a day.

UnitedHealthcare®

*Because of the potential for conflict of interest, legal consultation will not be provided on issues that may involve legal action against UnitedHealthcare or its affiliates, or an entity through which the caller is receiving Care24 services, directly or indirectly (e.g., employer or health plan).

Nurses can't diagnose problems nor recommend specific treatment. They are not a substitute for your doctor's care.

The Care24® program integrates elements of traditional employee assistance and work-life programs with health information lines for a comprehensive set of resources. It is not a substitute for a doctor's or professional's care. Due to the potential for a conflict of interest, legal consultation will not be provided on issues that may involve legal action against UnitedHealthcare or its affiliates, or any entity through which the caller is receiving these services directly or indirectly (e.g., employer or health plan). This program and its components may not be available in all states or for all group sizes and are subject to change. Coverage exclusions and limitations may apply.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

Facebook.com/UnitedHealthcare Twitter.com/UHC Instagram.com/UnitedHealthcare YouTube.com/UnitedHealthcare

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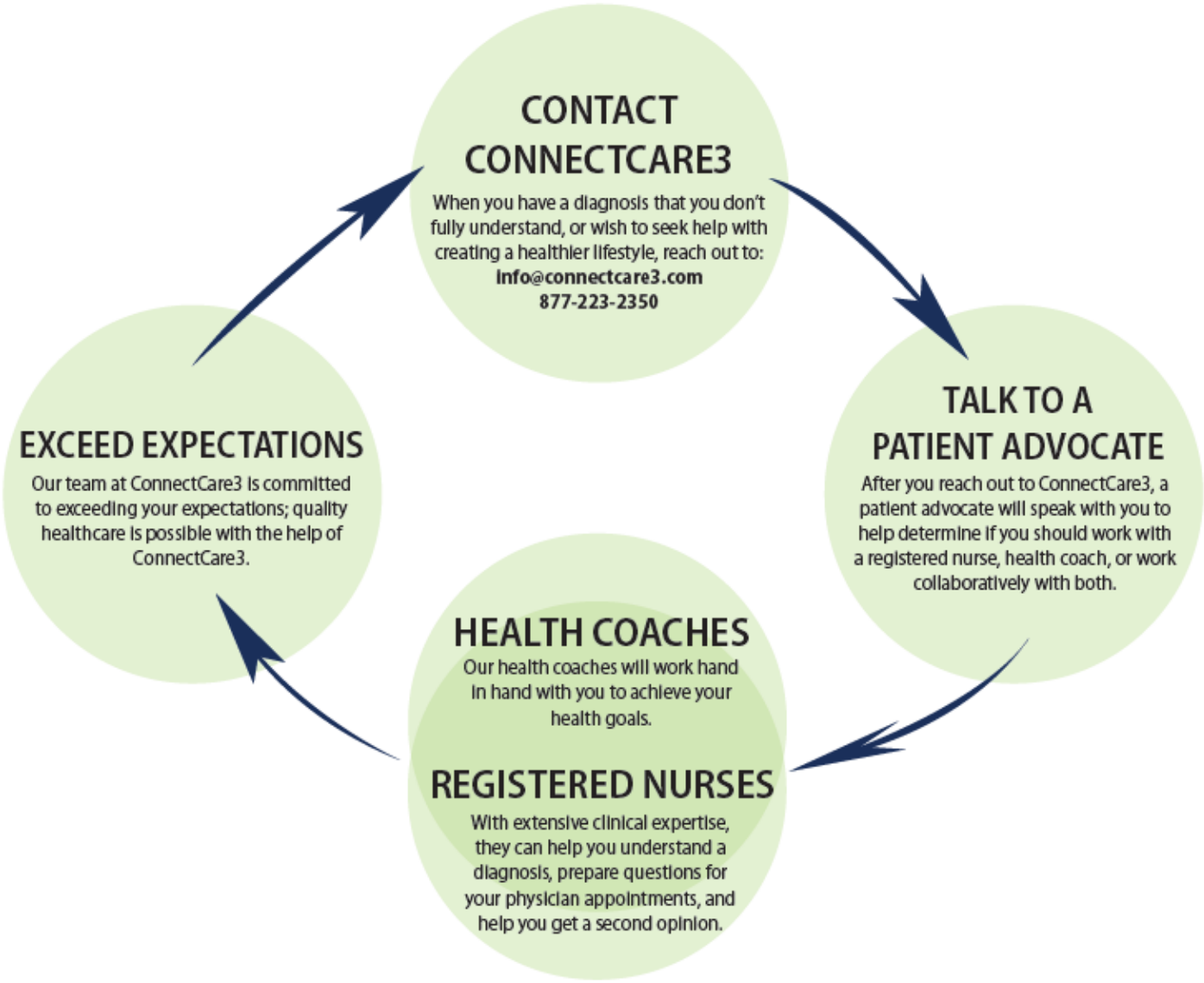
ConnectCare3

ConnectCare3 is a nurse navigation, patient advocacy and wellness service provided by your employer as part of your benefits for all employees and dependents on the medical plan. The team at ConnectCare3 strives to provide highly personalized care and any service provided remains confidential.



Call: 877-223-2350
Email: info@connectcare3.com
Website: connectcare3.com

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DENTAL & VISION INSURANCE RATES EFFECTIVE APRIL 1, 2019

Dental	
	Employee Pays (Per Payroll Deduction)
Employee Only	$0
Employee + Spouse	$6.75
Employee + Child(ren)	$6.47
Family	$13.61

Vision	
	Employee Pays (Per Payroll Deduction)
Employee Only	$0
Employee + Spouse	$0.85
Employee + Child(ren)	$0.77
Family	$1.69

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SUN LIFE DENTAL PLAN

Network: Sun Life Dental
Website: www.sunlife.com

For dental frequencies, please refer to the certificate of coverage or benefit summary.

Benefits	Sun Life Dental PPO	
	PPO Network	Out-of-Network[1]
Annual Deductible	$50 per individual and $150 per family Deductible is waived for Preventive Services	$50 per individual and $150 per family Deductible is waived for Preventive Services
Annual Plan Maximum	$1,000 per individual	
Orthodontia Lifetime Maximum	$1,000 lifetime per child under age 26	
Type I: Preventive Services		
Routine Exam	Plan pays 100%	Plan pays 100% [1]
Teeth Cleaning	Plan pays 100%	Plan pays 100% [1]
X-rays (Panoramic, Bitewings)	Plan pays 100%	Plan pays 100% [1]
Sealants - Child to Age 14	Plan pays 100%	Plan pays 100% [1]
Fluoride - Child to Age 14	Plan pays 100%	Plan pays 100% [1]
Type II: Basic Services		
Simple Extractions	Plan pays 100%	Plan pays 80% [1]
Fillings	Plan pays 100%	Plan pays 80% [1]
Space Maintainers - Child to Age 19	Plan pays 100%	Plan pays 80% [1]
Type III: Major Services		
Root Canal Therapy	Plan pays 60%	Plan pays 50% [1]
Bridges	Plan pays 60%	Plan pays 50% [1]
Dentures	Plan pays 60%	Plan pays 50% [1]
Crowns	Plan pays 60%	Plan pays 50% [1]
Complex Surgical Extractions	Plan pays 60%	Plan pays 50% [1]
Type IV: Orthodontic Services		
Orthodontia Treatment - Child to Age 19	Plan pays 50%	Plan pays 50% [1]
1 If you use a non-network provider, you are responsible for paying the difference in cost between the non-network provider's charges and the allowed amount.		

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DENTAL Q&A

How does a PPO work?

PPO stands for Participating Provider Organization. With a dental PPO plan, dental providers agree to participate in a dental network by offering discounted fees on most dental procedures. When you visit a provider in the network, you could see lower out-of-pocket costs because providers in the network agree to these pre-negotiated discounted fees on eligible claims.

How do I find a dentist?

Simply visit www.sunlife.com/findadentist . Follow the prompts to find a dentist in your area who participates in the PPO network. You do not need to select a dentist in advance.

Do I have to choose a dentist in the PPO network?

No. You can visit any licensed dentist for services. However, you could see lower out-of-pockets costs when you visit a dentist in the network.

Where do I find my dental ID card?

Your personalized electronic dental ID card is available through Online Advantage. You can register at www.sunlife.com/onlineadvantage . Please present this card to your dentist at your next visit to show that you are covered by a Sun Life Dental plan.

What if I have already started dental work…like a root canal or braces…that requires several visits?

Your coverage with us and your prior plan may handle these procedures differently. To ensure a smooth transition for work in progress, call our dental claims experts before your next visit at 800-442-7742.

Is it necessary to request a pre-determination of benefits prior to receiving services?

A pre-determination of benefits allows Sun Life to review your provider's plan for treatment before the work is done. We can tell you ahead of time how much of the work will probably be covered by the plan, and how much you may need to cover. If the charge for any dental treatment is expected to exceed $300, it is recommended that a dental treatment plan be submitted for review before treatment begins.

Do I have to file the claim?

Dentists in the PPO network will file claims for you. Some non-network dentists will file claims for you as well. If a nonnetwork dentist will not file your claim, simply ask your dentist to complete a standard American Dental Association (ADA) claim form and mail it to:

Sun Life Financial

P.O. Box 2940

Clinton, IA 52733

How can I get more information about my coverage?

After the effective date of your coverage, you can visit www.sunlife.com/onlineadvantage to create an account with Online Advantage. Once you're logged in, you'll be able to see your plan details, personalized dental ID card, and more. Or you can call Sun Life's Dental Customer Service at 800-442-7742. You can also call any time, day or night, to access our automated system and get answers to common questions when it's convenient for you.

For Limitations & Exclusions, please refer to the certificate of coverage or benefit summary.

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Life's brighter under the sun

BENEFIT TOOLS

Let Sun Life help you discover the true benefit of benefits—anytime, anywhere.

With the Benefit Tools app, you can easily view your dental and vision coverage, find a dentist, access your electronic dental ID card, and more.

Use this app to quickly access:

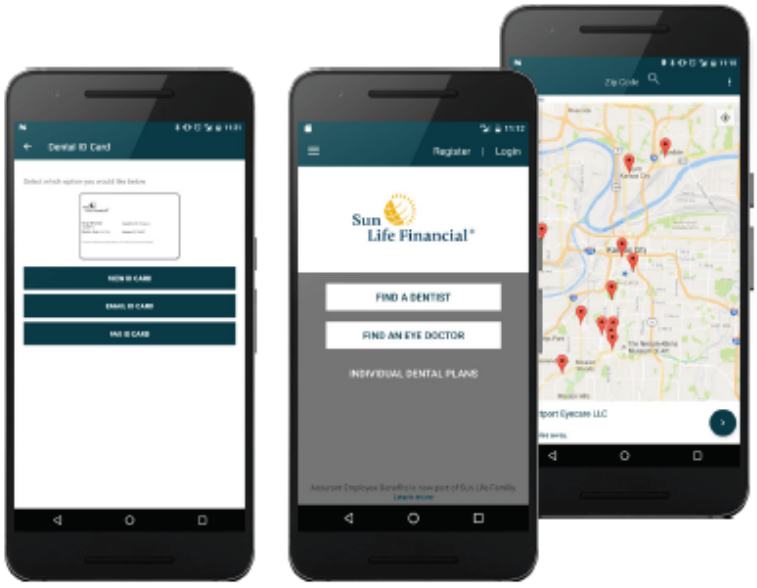
- My Benefits—An overview of dental and vision plan details
- Dental ID Card—Your electronic dental ID card
- Find a Dentist—Uses your location to find a dentist nearby
- Find an Eye Doctor—Uses your location to find an eye doctor nearby
- Contact Us—To connect with us to ask questions
- Individual dental plans—To learn about the products we sell in your area

Available for iPhone and Android devices.
Download now:

Download on the App Store

Google play

The Benefit Tools app is available for iPad and Android Tablets.
For more information, please visit www.sunlife.com/mobileapps



Dental ID Card

Find a Dentist/
Find a Doctor

Sun Life Financial®

One Sun Life Executive Park
Wellesley Hills, MA 02481

www.sunlife.com/us

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SLPC 27854 10/16 (exp. 10/18)

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SUN LIFE VISION PLAN

Network: VSP
Website: Sunlife.com

Benefits	Sun Life Vision	
	In-Network	Out-of-Network
Eye Exams	$10 copay	Reimbursed up to $45
Eyeglass Lenses and Frames		
Single Standard Lenses	$25 copay	Reimbursed up to $30
Bifocal Standard Lenses	$25 copay	Reimbursed up to $50
Trifocal Standard Lenses	$25 copay	Reimbursed up to $60
Lenticular Standard Lenses	$25 copay	Reimbursed up to $100
Frames	$130 allowance; 20% off balance	Reimbursed up to $70
Contact Lenses		
Standard Fit and Follow Up	Up to $60 copay	Reimbursed up to $105
Elective Lenses	$130 allowance	Reimbursed up to $105
Medically Necessary Lenses	Paid in Full	Reimbursed up to $210
Frequency		
Eye Exam	Once every 12 months	
Lenses—Eyeglass or Contact	Once every 12 months	
Frames	Once every 24 months	

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VISION Q&A

How do I use my vision benefit?

Once enrolled, simply tell your VSP doctor you're a member and they will handle the rest. If you visit an in-network doctor for services and materials, you don't need an ID card or have forms to complete.

How do I locate an in-network VSP doctor?

There are three ways to find an in-network doctor:

1. Visit vsp.com and select the Choice network.

2. Call 800-877-7195.

3. Download our mobile app, Benefit Tools, and search for a doctor near you.

What happens if I use an out-of-network doctor?

You will be required to pay the full amount to the doctor at time of service. You can then submit a claim for reimbursement, which is a lesser benefit when compared to visiting a VSP doctor.

When will my coverage become effective?

Your coverage starts on the effective date specified in your group policy, provided you are at active work on that date. Otherwise, your coverage will become effective on the day you return to full-time duties.

Can I enroll as a late entrant?

If you elect coverage more than 31 days after your eligibility date, your effective date will be delayed to the next plan anniversary date.

How can I get more information about my coverage?

After the effective date of your coverage, you can visit www.sunlife.com/onlineadvantage to create an account with Online Advantage. Once you're logged in, you'll be able to see your plan details and more. Or you can call Customer Service at 800 -877-7195.

For Limitations & Exclusions, please refer to the certificate of coverage or benefit summary.

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SUN LIFE BASIC LIFE/AD&D & VOLUNTARY LIFE INSURANCE

Group Life and AD&D Insurance

Group Life and AD&D Insurance is arranged through Sun Life. All eligible employees receive a life and accidental death & dismemberment (AD&D) insurance benefit of $20,000. This benefit is provided at no cost to you.

Voluntary and AD&D Life Insurance

Voluntary Life and AD&D Insurance is arranged through Sun Life. You have the option of purchasing additional Life and AD&D Insurance at attractive rates and the convenience of payroll deduction. Your cost is based on age and amount of coverage you select. Age-related cost adjustments will occur on the policy anniversary date, April 1. You must elect coverage for yourself to cover your spouse/children. Spouse premium is based on the spouse's age. Children are not eligible for AD&D coverage.

When initially eligible, you are guaranteed the insurance amounts below without submitting any evidence of insurability (EOI) or proof of good health as long as you enroll within 31 days of your initial eligibility date. Any life insurance coverage over the Guarantee Issue Amount will be subject to evidence of insurability. It is your responsibility to complete and submit the required EOI forms, to obtain the amount in excess of the guarantee issue amount, within 31 days of the date you apply for coverage. If you choose not to participate at the time you are initially eligible and elect to enroll at a later time, you may be required to submit evidence of insurability for all amounts of coverage.

Coverage	Benefit Amounts	Guarantee Issue
Employee	Increments of $10,000 up to a maximum of $500,000, but not to exceed 5x your basic annual earnings. Coverage ends at termination of employment or retirement.	$100,000
Spouse	Increments of $5,000 up to a maximum of $150,000, but not to exceed 50% of the employee coverage amount. Spouse coverage terminates at age 70.	$25,000
Child(ren)	Increments of $1,000 up to a maximum of $10,000, but not to exceed 50% of the employee coverage amount. A full benefit is payable for a dependent child who is 6 months to 19 years old or to age 23 if a full time student. A reduced benefit is payable for a child from 14 days to 6 months.	$10,000

Important Reminders

Group Life and AD&D Insurance benefits reduce to 65% at age 65 and to 45% at age 70.

Voluntary Life and AD&D Insurance benefits reduce to 65% at age 65, 45% at age 70, 30% at age 75, 20% at age 80 and 15% at age 85.

You must be actively at work on the effective date or your coverage will be delayed until you return to active employment.

For Limitations & Exclusions, please refer to the certificate of coverage or benefit summary.

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SUN LIFE EMPLOYEE LIFE RATES

Rates are effective as of April 01, 2019.
The chart below shows possible coverage amounts and the corresponding costs per Semi-Monthly pay period.
Find your age bracket (as of the effective date of coverage) to determine the associated cost of the coverage amount you choose.

Employee - Coverage and **Semi-Monthly** cost for Employee **Voluntary Life and AD&D**

	Age and Cost											
Coverage Amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$10,000	0.47	0.52	0.57	0.62	0.82	1.27	2.07	3.27	3.97	6.77	10.47	12.07
$20,000	0.93	1.03	1.13	1.23	1.63	2.53	4.13	6.53	7.93	13.53	20.93	24.14
$30,000	1.40	1.55	1.70	1.85	2.45	3.80	6.20	9.80	11.90	20.30	31.40	36.21
$40,000	1.86	2.06	2.26	2.46	3.26	5.06	8.26	13.06	15.86	27.06	41.86	48.28
$50,000	2.33	2.58	2.83	3.08	4.08	6.33	10.33	16.33	19.83	33.83	52.33	60.35
$60,000	2.79	3.09	3.39	3.69	4.89	7.59	12.39	19.59	23.79	40.59	62.79	72.42
$70,000	3.26	3.61	3.96	4.31	5.71	8.86	14.46	22.86	27.76	47.36	73.26	84.49
$80,000	3.72	4.12	4.52	4.92	6.52	10.12	16.52	26.12	31.72	54.12	83.72	96.56
$90,000	4.19	4.64	5.09	5.54	7.34	11.39	18.59	29.39	35.69	60.89	94.19	108.63
$100,000	4.65	5.15	5.65	6.15	8.15	12.65	20.65	32.65	39.65	67.65	104.65	120.70
$110,000	5.12	5.67	6.22	6.77	8.97	13.92	22.72	35.92	43.62	74.42	115.12	132.77
$120,000	5.58	6.18	6.78	7.38	9.78	15.18	24.78	39.18	47.58	81.18	125.58	144.84
$130,000	6.05	6.70	7.35	8.00	10.60	16.45	26.85	42.45	51.55	87.95	136.05	156.91
$140,000	6.51	7.21	7.91	8.61	11.41	17.71	28.91	45.71	55.51	94.71	146.51	168.98
$150,000	6.98	7.73	8.48	9.23	12.23	18.98	30.98	48.98	59.48	101.48	156.98	181.05
$160,000	7.44	8.24	9.04	9.84	13.04	20.24	33.04	52.24	63.44	108.24	167.44	193.12
$170,000	7.91	8.76	9.61	10.46	13.86	21.51	35.11	55.51	67.41	115.01	177.91	205.19
$180,000	8.37	9.27	10.17	11.07	14.67	22.77	37.17	58.77	71.37	121.77	188.37	217.26
$190,000	8.84	9.79	10.74	11.69	15.49	24.04	39.24	62.04	75.34	128.54	198.84	229.33
$200,000	9.30	10.30	11.30	12.30	16.30	25.30	41.30	65.30	79.30	135.30	209.30	241.40
$210,000	9.77	10.82	11.87	12.92	17.12	26.57	43.37	68.57	83.27	142.07	219.77	253.47
$220,000	10.23	11.33	12.43	13.53	17.93	27.83	45.43	71.83	87.23	148.83	230.23	265.54
$230,000	10.70	11.85	13.00	14.15	18.75	29.10	47.50	75.10	91.20	155.60	240.70	277.61
$240,000	11.16	12.36	13.56	14.76	19.56	30.36	49.56	78.36	95.16	162.36	251.16	289.68
$250,000	11.63	12.88	14.13	15.38	20.38	31.63	51.63	81.63	99.13	169.13	261.63	301.75
$260,000	12.09	13.39	14.69	15.99	21.19	32.89	53.69	84.89	103.09	175.89	272.09	313.82
$270,000	12.56	13.91	15.26	16.61	22.01	34.16	55.76	88.16	107.06	182.66	282.56	325.89
$280,000	13.02	14.42	15.82	17.22	22.82	35.42	57.82	91.42	111.02	189.42	293.02	337.96
$290,000	13.49	14.94	16.39	17.84	23.64	36.69	59.89	94.69	114.99	196.19	303.49	350.03
$300,000	13.95	15.45	16.95	18.45	24.45	37.95	61.95	97.95	118.95	202.95	313.95	362.10
$310,000	14.42	15.97	17.52	19.07	25.27	39.22	64.02	101.22	122.92	209.72	324.42	374.17
$320,000	14.88	16.48	18.08	19.68	26.08	40.48	66.08	104.48	126.88	216.48	334.88	386.24
$330,000	15.35	17.00	18.65	20.30	26.90	41.75	68.15	107.75	130.85	223.25	345.35	398.31
$340,000	15.81	17.51	19.21	20.91	27.71	43.01	70.21	111.01	134.81	230.01	355.81	410.38
$350,000	16.28	18.03	19.78	21.53	28.53	44.28	72.28	114.28	138.78	236.78	366.28	422.45
$360,000	16.74	18.54	20.34	22.14	29.34	45.54	74.34	117.54	142.74	243.54	376.74	434.52
$370,000	17.21	19.06	20.91	22.76	30.16	46.81	76.41	120.81	146.71	250.31	387.21	446.59
$380,000	17.67	19.57	21.47	23.37	30.97	48.07	78.47	124.07	150.67	257.07	397.67	458.66
$390,000	18.14	20.09	22.04	23.99	31.79	49.34	80.54	127.34	154.64	263.84	408.14	470.73
$400,000	18.60	20.60	22.60	24.60	32.60	50.60	82.60	130.60	158.60	270.60	418.60	482.80
$410,000	19.07	21.12	23.17	25.22	33.42	51.87	84.67	133.87	162.57	277.37	429.07	494.87
$420,000	19.53	21.63	23.73	25.83	34.23	53.13	86.73	137.13	166.53	284.13	439.53	506.94
$430,000	20.00	22.15	24.30	26.45	35.05	54.40	88.80	140.40	170.50	290.90	450.00	519.01
$440,000	20.46	22.66	24.86	27.06	35.86	55.66	90.86	143.66	174.46	297.66	460.46	531.08
$450,000	20.93	23.18	25.43	27.68	36.68	56.93	92.93	146.93	178.43	304.43	470.93	543.15
$460,000	21.39	23.69	25.99	28.29	37.49	58.19	94.99	150.19	182.39	311.19	481.39	555.22
$470,000	21.86	24.21	26.56	28.91	38.31	59.46	97.06	153.46	186.36	317.96	491.86	567.29
$480,000	22.32	24.72	27.12	29.52	39.12	60.72	99.12	156.72	190.32	324.72	502.32	579.36
$490,000	22.79	25.24	27.69	30.14	39.94	61.99	101.19	159.99	194.29	331.49	512.79	591.43
$500,000	23.25	25.75	28.25	30.75	40.75	63.25	103.25	163.25	198.25	338.25	523.25	603.50

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SUN LIFE SPOUSE & CHILD LIFE RATES

Rates are effective as of April 01, 2019.
The chart below shows possible coverage amounts and the corresponding costs per Semi-Monthly pay period.
Find your age bracket (as of the effective date of coverage) to determine the associated cost of the coverage amount you choose.

Spouse - Coverage and **Semi-Monthly** cost for Spouse **Voluntary Life and AD&D**

	Age and Cost									
Coverage Amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
$5,000	0.20	0.23	0.25	0.28	0.38	0.60	1.00	1.60	1.95	3.35
$10,000	0.41	0.46	0.51	0.56	0.76	1.21	2.01	3.21	3.91	6.71
$15,000	0.61	0.68	0.76	0.83	1.13	1.81	3.01	4.81	5.86	10.06
$20,000	0.81	0.91	1.01	1.11	1.51	2.41	4.01	6.41	7.81	13.41
$25,000	1.01	1.14	1.26	1.39	1.89	3.01	5.01	8.01	9.76	16.76
$30,000	1.22	1.37	1.52	1.67	2.27	3.62	6.02	9.62	11.72	20.12
$35,000	1.42	1.59	1.77	1.94	2.64	4.22	7.02	11.22	13.67	23.47
$40,000	1.62	1.82	2.02	2.22	3.02	4.82	8.02	12.82	15.62	26.82
$45,000	1.82	2.05	2.27	2.50	3.40	5.42	9.02	14.42	17.57	30.17
$50,000	2.03	2.28	2.53	2.78	3.78	6.03	10.03	16.03	19.53	33.53
$55,000	2.23	2.50	2.78	3.05	4.15	6.63	11.03	17.63	21.48	36.88
$60,000	2.43	2.73	3.03	3.33	4.53	7.23	12.03	19.23	23.43	40.23
$65,000	2.63	2.96	3.28	3.61	4.91	7.83	13.03	20.83	25.38	43.58
$70,000	2.84	3.19	3.54	3.89	5.29	8.44	14.04	22.44	27.34	46.94
$75,000	3.04	3.41	3.79	4.16	5.66	9.04	15.04	24.04	29.29	50.29
$80,000	3.24	3.64	4.04	4.44	6.04	9.64	16.04	25.64	31.24	53.64
$85,000	3.44	3.87	4.29	4.72	6.42	10.24	17.04	27.24	33.19	56.99
$90,000	3.65	4.10	4.55	5.00	6.80	10.85	18.05	28.85	35.15	60.35
$95,000	3.85	4.32	4.80	5.27	7.17	11.45	19.05	30.45	37.10	63.70
$100,000	4.05	4.55	5.05	5.55	7.55	12.05	20.05	32.05	39.05	67.05
$105,000	4.25	4.78	5.30	5.83	7.93	12.65	21.05	33.65	41.00	70.40
$110,000	4.46	5.01	5.56	6.11	8.31	13.26	22.06	35.26	42.96	73.76
$115,000	4.66	5.23	5.81	6.38	8.68	13.86	23.06	36.86	44.91	77.11
$120,000	4.86	5.46	6.06	6.66	9.06	14.46	24.06	38.46	46.86	80.46
$125,000	5.06	5.69	6.31	6.94	9.44	15.06	25.06	40.06	48.81	83.81
$130,000	5.27	5.92	6.57	7.22	9.82	15.67	26.07	41.67	50.77	87.17
$135,000	5.47	6.14	6.82	7.49	10.19	16.27	27.07	43.27	52.72	90.52
$140,000	5.67	6.37	7.07	7.77	10.57	16.87	28.07	44.87	54.67	93.87
$145,000	5.87	6.60	7.32	8.05	10.95	17.47	29.07	46.47	56.62	97.22
$150,000	6.08	6.83	7.58	8.33	11.33	18.08	30.08	48.08	58.58	100.58

Spouse rate based on Spouse Age

Child - Coverage and **Semi-Monthly** cost

Coverage Amounts	Voluntary Life Cost
$1,000	0.10
$2,000	0.19
$3,000	0.29
$4,000	0.38
$5,000	0.48
$6,000	0.57
$7,000	0.67
$8,000	0.76
$9,000	0.86
$10,000	0.96

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The Newborn's and Mother's Health Protection Act

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).

Women's Health and Cancer Rights Act (WHCRA) – Enrollment Notice

The Women's Health and Cancer Rights Act of 1998 (WHCRA) provides protections for individuals who elect breast reconstruction after a mastectomy. Under WHCRA, group health plans offering mastectomy coverage must provide coverage for certain services relating to the mastectomy, in a manner determined in consultation with the attending physician and the patient.
The required coverage includes:

- 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; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Under WHCRA, mastectomy benefits may be subject to annual deductibles and coinsurance consistent with those established for other benefits under the plan or coverage. Group health plans, health insurance companies and HMOs covered by the law must provide written notification to individuals of the coverage required by WHCRA upon enrollment and annually thereafter. If you would like more information on WHCRA benefits, call Member Services on the back of your health insurance ID card.

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Important Notice from City of Groveland 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 City of Groveland 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:

- 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.
- City of Groveland has determined that the prescription drug coverage offered by UnitedHealthcare 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 City of Groveland coverage will be affected. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will not be eligible to receive all of your current health and prescription drug benefits. UnitedHealthcare administers the group health coverage available to City of Groveland employees, retirees and dependents. The included prescription drug benefit provides:

	Network	Non-Network	Mail Order
Tier 1	$10	30% Coinsurance	$20
Tier 2	$40	30% Coinsurance	$40
Tier 3	$70	30% Coinsurance	$140
Tier 4	25% Coinsurance	30% Coinsurance	25% Coinsurance

If you do decide to join a Medicare drug plan and drop your current City of Groveland coverage, be aware that you and your dependents will not be able to get this coverage back.

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 City of Groveland 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 City of Groveland changes. You also may request a copy of this notice at any time.

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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: 03/12/2019
Name of Entity/Sender: City of Groveland
Contact--Position/Office: Deo Persaud / HR Director
Address: 156 S Lake Ave, Groveland, FL 34736
Phone Number: 352-429-2141

DocuSign Envelope ID: 8E8A42D1-BFB4-4EDA-B932-9F017C81BA9A

Important Notice from City of Groveland 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 City of Groveland 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:

- 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.
- City of Groveland has determined that the prescription drug coverage offered by UnitedHealthcare 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 City of Groveland coverage will be affected. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will not be eligible to receive all of your current health and prescription drug benefits. UnitedHealthcare administers the group health coverage available to City of Groveland employees, retirees and dependents. The included prescription drug benefit provides:

	Network	Non-Network	Mail Order
Tier 1	$10	30% Coinsurance	$20
Tier 2	$45	30% Coinsurance	$90
Tier 3	$90	30% Coinsurance	$180
Tier 4	25% Coinsurance	30% Coinsurance	25% Coinsurance

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

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New Health Insurance Marketplace Coverage Options & Your Health Coverage

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 your Human Resources 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.

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.

1

3. Employer Name **City of Groveland**	**4. Employer Identification Number (EIN)**	
5. Employer Address **156 S Lake. Ave**	**6. Employer Phone Number** **352-429-2141**	
7. City **Groveland**	**8. State** **Florida**	**9. ZIP Code** **34736**
10. Who can we contact about employee health coverage at this job? **Deo Persaud**		
11. Phone Number **352-429-3852**	**12. Email Address** **deo.persaud@groveland-fl.gov**	

[1]An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs

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Here is some basic information about health coverage offered by this employer:

As your employer, we offer a health plan to:

☐ All employees.

☒ Some employees. Eligible employees are working 30 or more hours per week.

With respect to dependents:

☒ We do offer coverage. Eligible dependents are: a spouse of the employee, a natural child, a stepchild, a legally adopted child, a child for whom legal guardian ship has been awarded to the employee or spouse, the newborn child of an enrolled dependent until the newborn reaches 18 months of age.

☐ 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** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.
The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☒**Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____(mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☒**Yes** (Go to question 15) ☐**No** (Stop and return this form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

How much would the employee have to pay in premiums for this plan per month? $0.00

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

A. How much will the employee have to pay in premiums per month for that plan? $_____

Date of Change: _____

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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 January 31, 2019. Contact your State for more information on eligibility –

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
GEORGIA – Medicaid
Website: www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507

To see if any other states have added a premium assistance program since January 31, 2019, 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

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City of Groveland

156 S Lake Ave., Groveland, FL 34736
352-4292141

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

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Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

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Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care • Share information in a disaster relief situation *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date: 04/01/2019

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Provided by Public Risk Insurance Advisors

Top 10 COBRA Mistakes and How to Avoid Them

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that employers provide former employees and dependents who lose group health benefits with an opportunity to continue group health insurance coverage for a limited period of time. Compliance with the complex rules regarding COBRA coverage can be difficult and mistakes can be costly. Penalties for noncompliance can include excise taxes and statutory fines. The risks also include lawsuits to compel coverage and costly adverse selection of COBRA coverage.

Most employer-sponsored group health plans are subject to COBRA's continuation coverage requirements. However, some employers, such as churches and small employers, are exempt from COBRA. In addition, certain welfare benefit plans, such as long-term and short-term disability plans, are not subject to COBRA because they do not provide medical care.

This Compliance Overview lists the most common mistakes made by employers and provides practical information and tips for avoiding the penalties and risks associated with these mistakes.

LINKS AND RESOURCES

- Employer's Guide to Group Health Continuation Coverage under COBRA, a DOL publication
- Frequently Asked Questions from the DOL on COBRA continuation coverage
- DOL's final rule on COBRA notice requirements

HIGHLIGHTS

PRACTICAL TIPS

- COBRA applies to employers that had 20 or more employees on typical business days during the preceding year.
- Qualifying events are events that cause loss of group health coverage and trigger COBRA coverage for qualified beneficiaries.
- Employers subject to COBRA must provide several notices to inform participants and beneficiaries of their rights.
- Plans subject to COBRA must have reasonable procedures in place for qualified beneficiaries to notify the plan administrator of certain events.

PRIA
PUBLIC RISK INSURANCE ADVISORS

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MISTAKE #10 – ASSUMING COBRA DOESN'T APPLY TO YOU

A threshold issue for COBRA compliance is whether COBRA even applies to you as an employer. The general rule is that COBRA applies to group health plans maintained by employers that have 20 or more employees. This includes private-sector employers, as well as state and local government employers.

The rule includes a built-in exemption for those employers that have fewer than 20 employees. Employers may be aware that there is an exemption, but may not know exactly how it works. Depending on the circumstances, determining how many employees you have for COBRA purposes can be a complicated calculation.

In general, COBRA will apply to employers that have 20 or more employees on **more than 50 percent of the typical business days in the previous calendar year**. This means that the calculation will apply for the entire calendar year; it does not change if the number of employees goes up or down. Thus, it can be dangerous to assume that you don't have to offer COBRA if your staff levels decrease.

Also, take care to count employees of companies that are under common control, as well as both full-time and part-time employees. A part-time employee counts as a fraction: divide the number of hours the employee worked by the number of hours required to be considered full-time.

MISTAKE #9 – ASSUMING COBRA DOESN'T APPLY TO YOUR PLAN

Once you have determined that COBRA applies to you as an employer, the next step is to figure out whether your health plan is subject to COBRA. As noted above, COBRA applies to group health plans maintained by employers.

A group health plan is an arrangement established to provide medical care to employees and their families and can be provided in a number of ways, including through insurance or a self-funded arrangement. A key point to note is **whether the plan provides medical care**.

Examples of health plans that may be subject to COBRA include:

- Medical, dental, vision and prescription drug plans;
- Drug and alcohol treatment programs;
- Employee assistance plans (EAPs) or wellness programs that provide medical care;
- On-site health care;
- Health flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs); and
- Self-funded medical reimbursement plans.

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Examples of health plans that may NOT be subject to COBRA (if they do not offer medical care) include:

- Long-term care plans;
- Accidental death and dismemberment plans;
- Group term life insurance plans;
- Long-term and short-term disability plans;
- Wellness programs or EAPs that do not provide medical care;
- Exercise or fitness centers; and
- On-site first-aid facilities.

Another potential pitfall to keep in mind is assuming that cancelling or terminating a health plan means that COBRA obligations terminate as well. If an employer terminates one plan but continues to provide any group health plan, the obligation to provide COBRA coverage continues.

Determining COBRA obligations in this type of situation can be especially complex when there is a merger or acquisition involved.

MISTAKE #8—NOT KNOWING WHO GETS COBRA AND WHEN

Employers and plan administrators should know who is entitled to COBRA coverage. Problems can arise if COBRA is not offered to someone who is eligible or if it *is* offered to a person who is *not* eligible to elect COBRA coverage. Under the COBRA rules, a "**qualifying event**" triggers COBRA coverage for "**qualified beneficiaries**" (QBs).

A **QB** is an individual covered by a group health plan on the day before the qualifying event.

A QB can be:

- The employee;
- The employee's spouse; and/or
- The employee's dependent child(ren).

In some cases, a retired employee (and his/her spouse and/or dependent children) can be a QB. In addition, a child born to or placed for adoption with the covered employee during the COBRA coverage period will become a QB.

Depending on the plan's eligibility rules, agents, independent contractors and directors could also be QBs.

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A **qualifying event** is a COBRA triggering event that:

- Is listed in the COBRA statute (see below); and
- Causes a loss of coverage under the plan.

The triggering events that will give rise to COBRA coverage depend on who is affected.

The following chart shows which events are qualifying events for each type of individual:

QUALIFYING EVENT	TRIGGERS COBRA COVERAGE FOR:
Termination of covered employee's employment (for reasons other than gross misconduct)	• Covered employee • Spouse • Dependent children
Reduction in hours of covered employee's employment	• Covered employee • Spouse • Dependent children
Covered employee becoming entitled to Medicare	• Spouse • Dependent children
Divorce or legal separation of covered employee	• Spouse • Dependent children
Death of covered employee	• Spouse • Dependent children
Loss of dependent child status under plan rules	• Dependent child

In addition to being familiar with the rules provided by the COBRA statute, it is important to look at the terms of the plan document. To be a qualifying event, the event must cause a loss of plan coverage. Just

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because a certain event is permitted to be a triggering event under COBRA does not mean it will cause a loss of coverage under the plan.

For example, COBRA allows the legal separation of the employee and his or her spouse to be a qualifying event, but the plan may only terminate coverage if the employee and spouse are divorced.

MISTAKE #7—GIVING NO INFORMATION

Once it is determined that a plan has to provide COBRA coverage, it is important to make sure that plan participants and beneficiaries are given adequate information about COBRA. The COBRA notice rules are important to understand, because failure to comply with them can lead to penalties under ERISA. Also, if participants and beneficiaries are not notified of their obligations, the plan's rules cannot be enforced.

The following are the required COBRA notices:

- **General (or Initial) Notice**. This notice provides general information to plan participants regarding COBRA and the plan's procedures. It must be provided **within 90 days after plan coverage begins** and must be written to be understood by the average plan participant. It may be provided as part of a Summary Plan Description. The COBRA notice rules specify the required content (see below) and the Department of Labor (DOL) has provided a model notice.

- **Election Notice**. The election notice is the most important notice for participants and beneficiaries who will be electing COBRA. It provides information about a qualified beneficiary's rights and obligations regarding a specific qualifying event and available COBRA coverage. It must be provided to qualified beneficiaries **within 14 days after the plan administrator is notified of the qualifying event**. However, if the employer is the plan administrator, the notice must be provided **within 44 days of the qualifying event or the loss of coverage** (whichever is later). The DOL has provided a model election notice as well.

- **Notice of Unavailability**. If an individual gives notice of a qualifying event but for some reason is not entitled to COBRA coverage, the plan administrator must give the individual **an explanation of why coverage is not available**. The deadline for this notice is the same as for the election notice.

- **Notice of Early Termination**. Normally, COBRA coverage will terminate at the end of the maximum coverage period. If coverage terminates early, qualified beneficiaries must be notified. This notice must be provided "**as soon as practicable**" after it is known that coverage will terminate (or has terminated). It must contain the reason for the early termination, the date coverage terminated or will terminate and a description of any available conversion rights.

- **Employer's Notice of Qualifying Event**. For certain qualifying events, the employer has the responsibility to notify the plan administrator of the event's occurrence. However, if the employer is the plan administrator, this notice is not required. If the event is the employee's death, termination of employment, reduction in hours of employment or Medicare entitlement, the employer must notify the plan administrator **within 14 days of the qualifying event or the**

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loss of coverage, whichever is later. The notice must include sufficient information to determine the plan, the employee, the qualifying event and the date it occurred.

MISTAKE #6—GIVING BAD INFORMATION

Unfortunately, making sure that you are providing notices in certain situations is not always enough. It is important to make sure that the notices you provide contain all the required information and that the information is accurate.

The following charts summarize the content requirements for the two major COBRA notices—**the general notice** and **the election notice**.

The General Notice must contain the following information to be compliant:

- The plan name;
- The name, address and phone number of a contact person who can provide information about the plan and COBRA;
- A description of COBRA coverage under the plan (including who can be a qualified beneficiary, the types of qualifying events under the plan, a description of the maximum coverage period and ways to extend it, and the plan's requirements for payment);
- The plan's procedures for qualified beneficiaries to provide notice of certain qualifying events or Social Security Administration (SSA) disability determinations;
- A statement that the notice does not fully describe COBRA coverage or other rights under the plan and that more information is available from the plan administrator or the Summary Plan Description (SPD); and
- A statement regarding the importance of advising the plan administrator of any change of address.

The Election Notice is the most detailed notice, since it relates to a specific qualifying event for specific QBs. It must contain the following elements:

- The plan name;
- The name, address and phone number of a contact person who can provide information about the plan and COBRA;
- Identification of the specific qualifying event;
- The date plan coverage will terminate;
- Identification of the QBs by status or name;

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- A statement that each QB has an independent right to elect COBRA coverage;
- A description of the COBRA coverage under the plan;
- The amount that each QB is required to pay for coverage and the procedures for making payments;
- An explanation of how to elect coverage and the date by which the election must be made;
- The consequences of failing to elect or of waiving COBRA coverage;
- The duration of COBRA coverage and how coverage may be extended;
- An explanation of the QB's responsibility to provide notice of a second qualifying event or SSA disability determination (or determination that the QB is no longer disabled), including a description of the procedures for providing notice;
- A statement that the notice does not fully describe COBRA coverage or other rights under the plan and that more information is available from the plan administrator or the SPD; and
- A statement regarding the importance of advising the plan administrator of any change of address.

MISTAKE #5—NOT FOLLOWING YOUR OWN RULES

There are several COBRA rules that require a plan to have procedures in place, whether by statute or necessity. Not following its procedures can put a plan in the position of being out of compliance with COBRA's requirements or of extending coverage for too long or unnecessarily.

Notice Procedures

With respect to the notice rules, plans must have reasonable procedures in place for covered employees and QBs to notify the plan administrator of certain events, such as:

- Qualifying events that are the divorce or legal separation of the covered employee or a dependent child losing dependent status under the plan;
- Second qualifying events (triggering events that occur during the period of COBRA coverage that would have caused a loss of coverage under the plan if the QB were still covered); and
- SSA disability determinations (or cessation of disability).

In general, individuals must provide a notice of a qualifying event or disability determination within 60 days. Disability determination notices must also be given before the end of the original 18-month COBRA coverage period. In addition, QBs must notify the plan administrator within 30 days of a determination that they are no longer disabled.

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If the plan does not have reasonable procedures for these notices, a QB may be deemed to have given notice if he or she has communicated a specific event in a manner reasonably calculated to inform those customarily considered responsible for the plan.

In order to be reasonable, COBRA notice procedures must:

- Be described in the SPD;
- Specify the individual or entity that should receive the notice;
- Specify how notice is to be given (for example, in writing or on a specific form);
- Describe the information required (such as the QBs involved, the date of the event, the nature of the event, the plan name and any additional documentation the plan administrator might want, such as a copy of a divorce decree);
- Specify the timeline for giving notice; and
- Provide for the proper handling of incomplete notices.

Election Procedures

A plan should also have procedures in place for complying with rules for election of COBRA coverage. For example, a QB must be given at least 60 days to elect COBRA. The election period begins on the date the election notice is provided or the date on which coverage would be lost (whichever is later).

Also, each QB has an independent right to elect COBRA, a covered employee or spouse can elect on behalf of all other QBs, and a parent or guardian can elect on behalf of a minor child. A QB may also revoke a prior waiver of COBRA coverage during the election period. A plan administrator that fails to follow the election procedures is at increased risk for claims by QBs.

Payment Procedures

As discussed below, a plan may charge a premium for providing COBRA coverage. QBs must make premium payments in a timely manner and a plan administrator has some leeway in designing its procedures. However, the COBRA rules set some guidelines for payments. The initial premium is due **45 days** after the COBRA election is made. After that, the premium due date is usually the first day of the month. However, the plan must allow a 30-day payment grace period.

In addition to complying with the COBRA rules, a plan should have procedures in place for dealing with issues that may arise in the day-to-day administration of COBRA coverage. For example, a plan will need a process for ensuring that premium payments are forwarded to insurers in a timely manner. Also, it should prepare for a situation where a QB makes late payments or short payments.

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MISTAKE #4—NOT GIVING ENOUGH COVERAGE

The continuation coverage provided to QBs under COBRA must be the same as coverage provided to "similarly situated" individuals who are covered under the plan (not through COBRA). This is intended to be the same coverage the QB had before the qualifying event.

Thus, COBRA coverage cannot be scaled back just for QBs and not for other plan participants. QBs are also entitled to the same benefits, rights and privileges that similarly situated participants and beneficiaries receive under the plan, such as special enrollment rights and the ability to make changes at open enrollment. If the plan's terms are amended, those amendments apply equally to active participants and QBs.

MISTAKE #3—CHARGING TOO MUCH (OR NOT ENOUGH)

A health plan may charge COBRA QBs for the cost of providing COBRA coverage. It may require QBs to pay **up to 102 percent** of the "applicable premium" for the plan. In the case of a disability extension, it may charge up to 150 percent of the applicable premium for certain QBs.

For insured plans, the applicable premium is usually equal to the insurance premium paid to the insurance carrier. However, the calculation can be more difficult for self-funded plans and can be determined using past costs or an actuarial estimate of future costs. The applicable premium is the total cost to the plan for providing coverage, so it includes both employer- and employee-paid portions and can also include the administrative cost of providing COBRA coverage.

The plan must calculate the COBRA applicable premium in advance for a 12-month "determination period." The plan can choose any 12-month period to be the determination period, but it must remain consistent every year. The COBRA premium may be changed for a new determination period if the applicable premium changes and there are certain limited situations where the COBRA premium may be changed during the determination period (for example, if the QB changes coverage to another benefit package with a higher applicable premium).

The plan administrator should use caution in calculating the COBRA premium as well as in communicating that premium to QBs. Fixing mistakes that result in over- or undercharging QBs for COBRA premiums can be administratively burdensome and raise COBRA compliance issues.

MISTAKE #2—NO DOCUMENTATION

No matter how good your COBRA compliance track record is, you can still run into trouble if you can't prove it. Adequate documentation is important because it brings together all other elements of COBRA administration and compliance. Having thorough and accurate records will help streamline administration and support the plan in the event of a claim.

There are many different areas where documentation can help avoid COBRA compliance issues. For example, a plan's COBRA notice information and procedures can be documented in the SPD and notice documents themselves, as well as the plan document if necessary.

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A plan administrator should also keep records of notices sent to and received from participants and QBs. Keeping track of payments received from QBs and made to insurers, as well as the deadlines for payments, will also assist in the proper administration of COBRA coverage.

MISTAKE #1—BAD TIMING

In the context of COBRA, paying attention to the timing of providing coverage can be crucial for reducing exposure to COBRA costs and being compliant with the rules. The duration of COBRA coverage is controlled by the COBRA statute. Complying with these rules by providing the length of coverage required is important. At the same time, many plan sponsors want to minimize the likelihood of being responsible for large claims made by COBRA QBs by only providing the minimum duration of coverage.

The period of COBRA coverage offered to QBs is known as the **maximum coverage period**.

The length of the maximum coverage period depends on the type of qualifying event that has occurred. The maximum coverage period is **18 months** for a termination of employment or reduction in hours and **36 months** for all other qualifying events. There are situations where the maximum coverage period can be extended or terminated early.

Expanding COBRA Coverage

There are several ways that the standard maximum coverage period can be extended. The following chart provides a summary of the available methods.

Disability Extension Rule	Extends 18-month period to 29 months for all related QBs
Multiple Qualifying Event Rule	Extends 18-month coverage period to 36 months for spouse and children when a second qualifying event (such as divorce from or death of the covered employee or loss of dependent status) occurs during the initial 18-month coverage period
Medicare Entitlement Rule	Extends 18-month period for spouses and children when the covered employee becomes entitled to Medicare within 18 months before the qualifying event

Terminating COBRA Coverage

COBRA coverage usually terminates at the end of the maximum coverage period. It is important to keep track of each QB's period of coverage to be able to tell when coverage should be terminated. In addition, coverage can be terminated early for the following reasons:

- The QB fails to make timely premium payments;
- The employer ceases to make any group health plan available to any employee;

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- The QB becomes covered under another group health plan;
- A disabled QB is determined not to be disabled; or
- For cause.

If coverage is to be terminated before the end of the maximum coverage period, notice to the QB is required.

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Make *Healthy Holiday* Choices

The holiday season brings party food, cookies, eggnog and other holiday treats that are often high-calorie, though tasty, choices.

Consider the following tips to enjoy your holiday parties without overindulging:

- Eat a healthy snack before heading for a party in order to avoid grazing on party food to satisfy your hunger.
- Make socializing your focus—conversation will keep you occupied and away from the food table.
- Abstain from or limit your drinking: Alcohol increases hunger and lowers willpower.

SPECIMEN

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B. Property & Casualty and C. Workers' Compensation

Technology and Additional Resources

PRIA's primary and most important function is to support our clients' objective in the utmost cost-effective manner. Technical resources are employed whenever improvements in processes or outcomes can be achieved. We have embraced technologically advanced systems in the past and are always searching for new tools to improve outcomes.

FEMA Public Assistance Coordination

Our vast experience in managing large property claims has led us to develop unique programs such as our FEMA Coordination program. This service was created in response to the difficulty that most public entities experienced in dealing with FEMA after the major storms in 2004. Our first initiative was to gain an intimate understanding of the Stafford Act and its implications in providing public assistance funds in Florida. We then met directly with FEMA representatives in the Lake Mary Long Term Disaster Recovery office and quickly established a procedure and protocol with FEMA personnel that will improve their ability to quickly pay public assistance funds to our clients. For example, we have provided a current client property policy and schedule to FEMA in advance of any losses so that FEMA will not need to request this information directly from our clients. We have also coordinated the efforts of the insurance company's loss adjusters to better align with the data that FEMA requires on their Project Worksheets. These Project Worksheets are an integral part of FEMA's reimbursement process and can significantly slow the process if they are not completed accurately. In the event of a major loss PRIA will be assisting in every step of the insurance company claims process as well as the FEMA reimbursement process. We are confident that with the processes in place we can effectively improve the expediting of claim payments in most cases by several weeks or more.

Flood Audit

This is a unique process that we have developed to keep up with FEMA's internal changes including flood mapping changes. We regularly review anticipated flood zone changes (which can employ a variety of methods) to determine impact to structures located in Special Flood Hazard Areas (SFHA's). The importance of this exercise is to determine and communicate the implications of FEMA and the Stafford Act to our clients.

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RiskMeter

RiskMeter is an online resource providing on-demand hazard risk data. This in-house subscription is utilized to be sure the most accurate and complete underwriting data is provided to the property underwriters via the Property Schedule.

Real Time Data Available for individual sites includes:

- Distance to Coast
- Flood Zone Determination including distance from SFHA zone
- Storm Surge Score
- FEMA Flood Insurance Rate Map and panel number

Property Management Tools

PRIA will make available to the District, at no cost, a valuable on-line Property Asset Management Tool. This property management web-based platform is offered by Asset Works, an industry leading appraisal and asset management company. The system is called AMP and provides the user with an easy and efficient tool to maintain data about buildings, contents, property in the open, vehicles, mobile equipment and other fixed assets. AMP can greatly increase the integrity of data and has complete conversion capability for catastrophic modeling, proof of loss documentation and a plethora of property-based reports.

More detail on the benefits and features of this tool can be found on the next two pages.

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AMP
ASSET MANAGEMENT PLATFORM

Property Risk Management

As an organization, being exposed to a variety of risks is inevitable – being prepared in the event of a risk occurrence is critical. When it comes to managing property data for your organization or risk pool, the AMP Property Risk Management module from AssetWorks offers an innovative approach to risk management. By maintaining data about buildings and structures, property-in-the-open, fixed assets, licensed vehicles, and secondary C.O.P.E. characteristics, in a single, comprehensive database, AMP can help bridge the gap between valuation results and valuation management.

AMP offers a convenient, efficient, and secure method of tracking and reporting data used for:

- Loss control
- Proof-of-loss documentation
- Catastrophe modeling
- Annual updating of values
- Property marketing and placement

With various levels of user access, approval processes, and a complete audit trail, AMP users can be confident in the integrity of their data. Data conversion capabilities for catastrophe modeling, reports for proof-of-loss documentation in the event of a catastrophe, and a simplified insurance renewal process make AMP the clear choice for property risk management.

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PROPERTY RISK MANAGEMENT

AMP
ASSET MANAGEMENT PLATFORM

PRODUCT HIGHLIGHTS:

Property Tracking

Functionality to track multiple individual organizations under one entity. Includes the tracking of primary and secondary COPE data and processes for updating new property and property disposal.

Valuation Management

Includes data trending capabilities using trend factors and a value approval process to facilitate the updating of property values. An insurable values benchmark tool allows users to see differences in proposed insurable values in relation to current insurable values.

Dynamic Reporting Tool

Standard reports are accessible in batch mode and can be filtered by search parameters. Includes reports to assist with data conversion for catastrophe modeling, proof-of-loss documentation, and the insurance renewal process.

System and Data Security

Various levels of user access defined at the entity, organization, site and building level as well as approval processes and a complete auditable history ensure the integrity of data being tracked.

Data Exchange

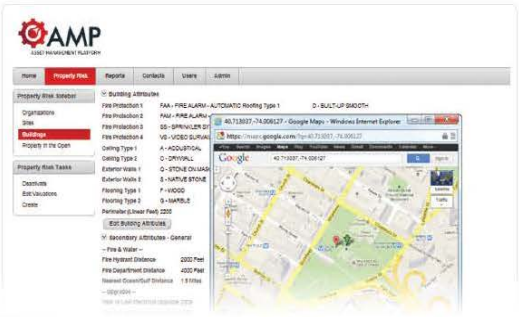
Allows asset and table data to be imported/exported in comma-delimited (CSV) and text formats

Document/Image Repository Management

Provides the ability to assign forms, documents, and image files to individual properties and assets

User-friendly Interface

The "Work Desk" capability allows statistics, reports and other visual tools to be attached to the home screen while an unlimited number of user defined fields allows users to track additional data elements.



BENEFITS:

- Streamline data communication processes and simplify the renewal process by maintaining all information in one sophisticated database, accessible by everyone in real-time.
- Increase efficiency with automated workflow processes for adding new properties, modifying existing property schedules, and removing entries from current property schedules.
- Save time preparing reports for data mapping for catastrophe modeling, proof-of-loss documentation, and the insurance renewal process.
- Rest assured that data is secure and accurate as a result of various levels of user access, approval processes, and a complete audit trail.
- Experience greater leverage in the insurance market with respect to coverage and premiums as a result of submitting accurate data and a detailed risk model.
- Reduced learning curve as a result of user friendly design and intuitive workflows.

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AssetWORKS

Property Modeling & Risk Analytics

We have a national contract with AIR Worldwide and their new **Touchstone** Platform. The Platform provides proprietary analytics and software program results featuring individual client risk exposures on multi-layered interactive maps. These highly sophisticated analyses provide a unique perspective of the risk most likely to affect operations.

- Interactive mapping capabilities provide instant geographic extent and accumulation of risk.
- Data cleansing and auditing to reduce uncertainty and ensure adequate data is represented in the modeling software utilized by insurers to evaluate risk, set rate and coverage terms
- Custom catastrophe and non-catastrophic modelling analysis
- Visualize your severe thunderstorm and terrorism risk
- Data quality analytics enable you to measure the quality of property risk data.
- Geo-visualization tool – Spatial Key

Procore Solutions + Consulting (Brown & Brown Subsidiary)

Disaster Planning

Procor was founded around a simple goal – identify, rethink and improve how the risk management, disaster planning and response, and the claims industry interacts, collaborates, and adds value for its participants and impacted communities. This unique Brown & Brown subsidiary provides resources of a group of highly specialized professionals with focus in the following areas:

- **Disaster Planning & Response**
- **Loss Mitigation**
- **Complex Claims recovery**
- **Forensic Accounting**
- **Business Interruption Exposure Identification & Claim management**
- **Industry-leading symposiums**
- **FEMA Claims & Grant Management**

Note, Procor's resources would be made available to the District however, additional fees may apply for specific projects.

Following a declared emergency or major disaster, public entities and some private non-profit organizations may be eligible for FEMA assistance through the Public Assistance (PA) Program. The PA program is designed to offer assistance to eligible entities but is not designed to make an entity "whole". FEMA assistance is subject to a cost share and is the payer of last resort. Therefore, eligible entities are required to turn to their insurance provider(s) and other possible funding sources (e.g. State grants) for further assistance. Cost indexing and claim submittals becomes more complex with each source, requiring unique and specific documentation submissions in order to prove a loss and then ultimately to release funds for reimbursement.

A loss where there are available funds to support a recovery via insurance, FEMA, and other funding agents, requires a comprehensive claim strategy, timeline and most importantly, details to effectuate a positive and quick resolution. Without a dedicated team leading the documentation and presentation effort in a collective manner and with deep knowledge and experience with the interplay of insurance and FEMA (and other funding agents), a recovery effort will likely encounter material differences in scope, pricing and expectation, which could yield to reimbursement delays or a shortage of funds.

Procor has the experience, expertise and technological support to coordinate and manage the recovery process. Procor's experts and strategic partners collaborate with all the interested parties, as well as insurance providers. FEMA representatives and other funding agents, to identify eligible reimbursable costs, document and support each component of loss, and effectively streamline the submittal process. Procor has assisted in the presentation and recovery of more than $1 Billion in public funding – and combined with their insurance expertise, makes Procor the unique choice for public entity agencies facing the daunting recovery task following a disaster or catastrophe.

Below are a few examples of Procor's successes:

- Procor was engaged by one of the largest NYC public entities that experienced a major loss resulting from Hurricane Sandy. The Procor team supported the insurance claim preparation package of over $400 Million. In addition, our experts supported the overall FEMA claim and associated grants management for $3 Billion in overall economic damages.
- Procor was engaged to quantify and present a $30 Million hurricane claim for one of the largest school districts in the Country. The School District needed a complex analysis of costs to be allocated across hundreds of individual building and campuses through the district. Procor set up an efficient data collection process and claim presentation format that allowed for multiple views of loss quantification allowing the district to analyze the loss as required. In addition to the insurance claim presentation, Procor also assisted in the determination and segregation of costs that could be eligible through FEMA reimbursement.

Depending on the Scope of Services, Procore may require additional fees.

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Business Continuity Planning and Claims

HURRICANE PREPAREDNESS

Pre- Loss Checklist

PROCOR
Solutions + Consulting

CHECKLIST	
☐	Review and understand the coverage provided by your insurance policies including: • How coverage is triggered. (examples: Service Interruption, Ingress/ Egress, Civil Authority, et al) • Overall Limits and Sublimits per area of your coverage • Deductibles and waiting periods • Indirect loss coverages such as Contingent Business Interruption, Consequential Damages
☐	Safeguard and duplicate records so they can be accessed in the event of loss or damage. • Offsite and/or cloud storage
☐	Consider maintaining a detailed inventory of machinery and equipment with accompanying photographs. • Not all property that can be claimed in an insurance loss will be on the fixed asset records. This may include fully depreciated assets and property that has been expensed rather than capitalized.
☐	Before the loss, set up a team that know roles and duties in the event a loss occurs. • Internal Team (Risk Management, Finance, HR, Maintenance) • External Team (Remediation/Restoration, Broker, Claims Advocate, Claims Prep/Forensic Accountant)
☐	Identify a designated point or contact person for each facility/division.
☐	Have a clear process set up to gather documents and data needed to quantify and support an insurance claim.

☐	Before a loss occurs, practice theoretical loss scenarios and plan "what ifs"
	• MFL (Maximum Foreseeable Loss)
	• AMBIL (Anticipated Maximum BI Loss)
	• Determine mitigation response(s)
	  • Potential to lease temporary facilities
	  • Redirecting or outsourcing of sales and/or production
	  • Other additional and/or extra expense scenarios
	• Estimate cost of mitigation responses

☐	Have a current business continuity plan in place • Use information and data obtained from theoretical loss scenarios

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TOUCHSTONE®

Own the risk.®

AIR WORLDWIDE®

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Reimagine Risk Management

The challenges today's risk managers face are relentless. Losses seem to grow larger with each new event. Non-modeled sources of risk suddenly emerge to reveal new vulnerabilities. Companies are searching for the path to continued profitable growth in a rapidly changing market environment and under ever stricter regulatory regimes.

To meet these challenges and seize emerging opportunities, risk managers need tools that empower them, not hold them captive; tools that provide transparency, flexibility, and choice; tools that allow them to own their risk. That's why we developed Touchstone.

Touchstone allows you to:

- Harness the power of AIR's industry-leading models
- Understand exposure accumulations and improve the quality of your exposure data
- Perform advanced sensitivity testing
- Consider alternative views of risk
- Manage global exposure to both modeled and non-modeled perils
- Gain insight into the sources of uncertainty and how to manage them
- Generate the information you need, when you need it

Touchstone is intuitive, powerful, flexible, and fast. Its customizable interfaces, streamlined database structures, and award-winning geospatial analytics enable you to better understand your results and improve your risk management decisions.

The next generation of catastrophe modeling is here.

UNDERSTAND YOUR BUSINESS AS NEVER BEFORE

Touchstone is architected to support best practices in today's catastrophe modeling workflow. Taking ownership of the risk starts with your exposure. With its interactive mapping capabilities, Touchstone's ***Exposure Overview*** allows you to instantly grasp the geographic extent of your portfolio and accumulations of risk on a global scale with customizable charts, tables, and maps. Zoom all the way down to street level and switch to satellite view for visual confirmation that the property is actually what and where your data says it is.

We all know that the reliability of model output is only as good as the quality of the exposure data used as input. Beyond seeing where your exposures are located, Touchstone's ***Data Quality Analytics*** enable you to measure and improve your data quality. Start with scoring so that you can target resources toward improving the quality of data in those policies or portfolios where it will have the greatest impact on your enterprise-wide risk profile. Validate your data against a comprehensive set of completeness and reasonability rules, and benchmark your data against that of the industry. For U.S. exposures, you can leverage Touchstone's comprehensive and detailed property-specific databases to fill in missing data or replace data that is questionable.

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Armed with a full grasp of your exposure data, you can run ***Loss Analytics*** using the same robust simulation methodology that has always been behind the AIR model. Quickly see various perspectives of loss, loss metrics, and uncertainty, all within the Touchstone user interface. After performing detailed loss analysis on high quality exposure data, the capabilities that make Touchstone truly groundbreaking become apparent.

With Touchstone's ***Hazard Analytics***, you can quickly identify the catastrophe hazards that threaten individual property locations. Check if a risk complies with underwriting guidelines—its distance to the coast, for example, or whether it's located on a particular soil type. Touchstone's hazard information is both broad and deep, ranging from liquefaction and landslide potential, to elevation and terrain, to FEMA flood zones and distance to return-period floodplains.

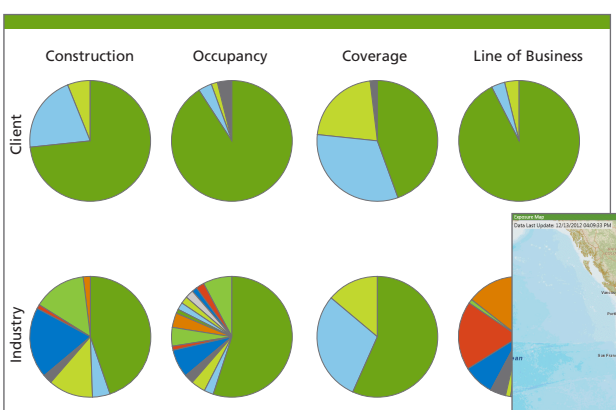
To facilitate model validation, Touchstone's Hazard Analytics also gives you direct access to location-level hazard information for simulated events—including wind speed, ground motion, and flood depth.

Bringing it all together are Touchstone's ***Geospatial Analytics***, which allow you to integrate exposure, hazard, and loss information. But unlike numbers on a spreadsheet, the visual intelligence Touchstone offers means rich and intuitive insight into your accumulations and how they relate to potential hazards. While tools for accumulation management have been a mainstay in catastrophe risk management for many years, Geospatial Analytics adds an essential layer of information that no other solution in the market can deliver.

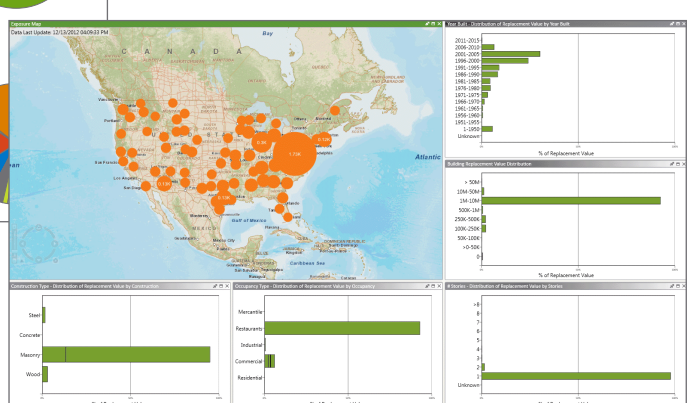
Not only can you combine exposure information for multiple lines of business with location-specific hazard data, but you can also leverage the power of Touchstone's financial module to apply policy and layer terms to run geospatial analyses based on your exposed limits. A full range of loss perspectives are available—including ground-up, gross, retained, and net of pre-cat.

EVOLVE FROM REPORTING TO INTERACTIVE DISCOVERY

Long gone are the days when annual or even monthly reporting was sufficient to manage your risk. Immediacy is the new norm. Touchstone is designed to always stay open on your desktop so that you can explore your data and results in an interactive manner, understand the risk at new levels of detail—and conduct analyses at near real time.



Benchmark your data against that of the industry using Data Quality Analytics



Exposure Data Overview

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What's the next step? You decide. Specify accumulation zones by political boundaries, user-defined regions, or custom-drawn polygons and ellipses. Automatically and accurately identify the ring that generates the highest accumulation through *dynamic ring analysis*. Perform concentric ring analyses to evaluate terrorism exposure around specific targets, anywhere in the world. Or analyze your accumulations of exposure and loss against the intensity footprints of significant historical events, realistic disaster scenarios, or your own hazard layers, and apply user-defined damage ratios to assess loss potential. The possibilities are limitless.

STREAMLINE YOUR WORKFLOW

Touchstone offers unparalleled ease of use and workflow efficiencies. The Reinsurance Submission Pack wizard minimizes clicks, ensures the fidelity of submissions, and facilitates information exchange between reinsurers and their cedants. Touchstone's comparative analytics let you track how loss results change over time, with different financial terms or analysis options, or across different model versions, all of which can be visualized intuitively with Touchstone's mapping features.

The ***Underwriting Mode*** provides detailed and customizable information about policies under consideration, allowing you to make faster and more consistent underwriting decisions. Define what analytics to perform in accordance with your company's guidelines, and display results within a single adaptable view.

CHOICE IN DEPLOYMENT TO MEET YOUR NEEDS

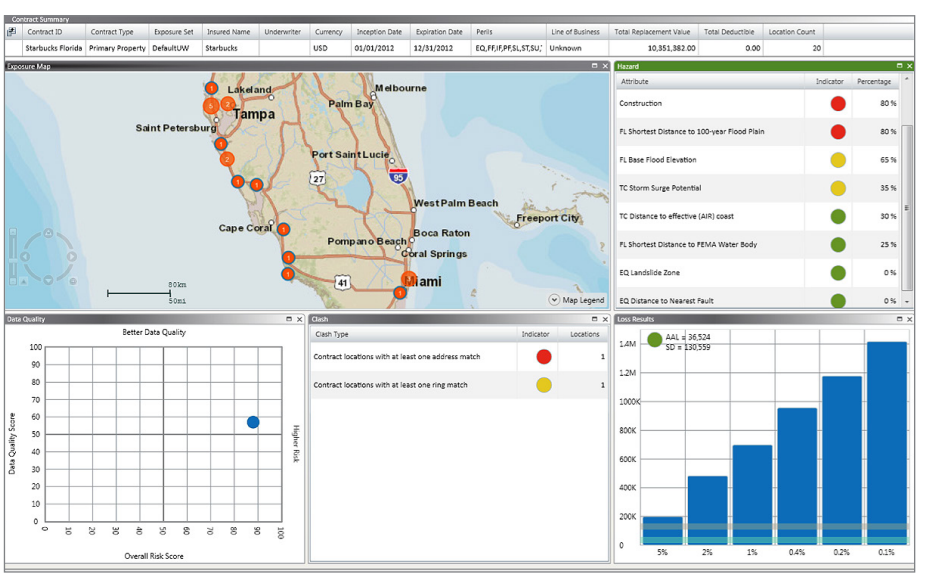
AIR will help you establish a catastrophe modeling environment that works best for your organization. Touchstone can be installed:

- In house or in your own private cloud
- In a third-party public cloud
- Integrated with your existing systems through APIs
- In an AIR-hosted cloud

Ultimately, the choice is yours.

Non-catastrophe analytics have also been integrated into Touchstone to give you a comprehensive understanding of how perils such as fire, lightning, explosions, and vandalism affect your risk profile. Non-cat perils can be assessed using custom loss costs or by leveraging ISO® data that can be seamlessly integrated into Touchstone.

No other risk analysis software can offer this level of workflow efficiency and integration, making Touchstone the leading platform for helping you make the best pricing, underwriting, and risk management decisions.



The Underwriting Mode's dashboard displays key analysis output—Data Quality, Clash, Loss, and Hazard—within a single window

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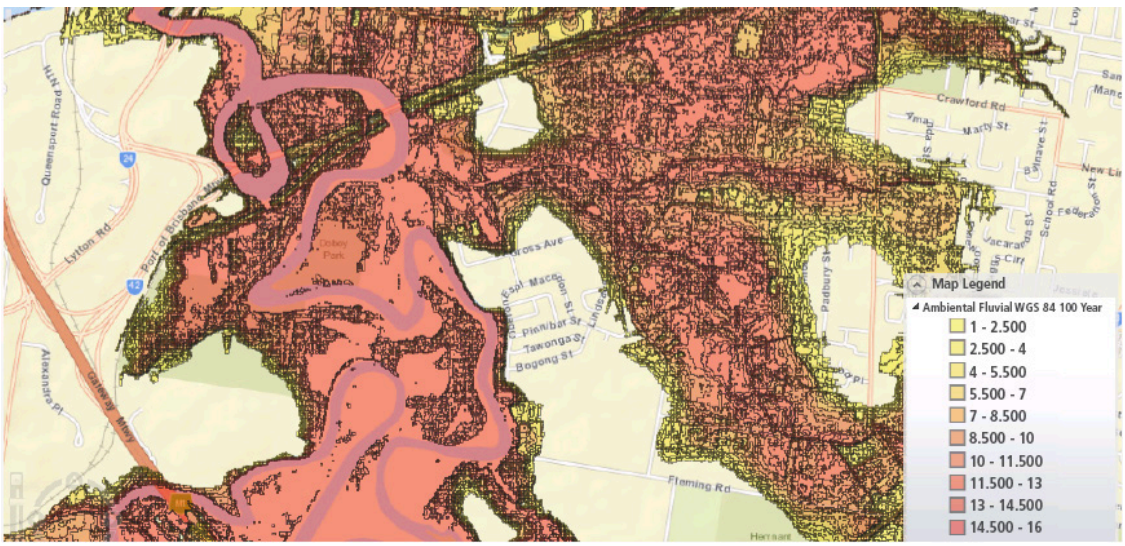

Integrate third-party data on a flexible, open platform

EFFECTIVELY USE ALL YOUR VERISK ASSETS

As a Verisk Analytics business, AIR is in a unique position to integrate Verisk data and products into Touchstone, giving you the means to effectively use all your Verisk assets within a single platform. Integration of Verisk data and products within Touchstone allows you to:

- Assess your non-catastrophe risk with ISO loss costs and PSOLD™
- Augment your exposure data quality by leveraging Touchstone's property-specific database, a blended data set that sources information from ProMetrix™, ISO PushPin, and Verisk's 360Value®
- Visualize and accumulate your severe thunderstorm and terrorism risk by importing data layers from Verisk Climate and Verisk Maplecroft

THE TECHNOLOGY TO MAKE IT POSSIBLE

Touchstone was designed to offer significant improvements in job scalability, cluster resource utilization, and overall system throughput. The end result is speed. Computationally complex analyses can be scaled in parallel across hundreds of cores, dramatically reducing model run times. You can ***run more analyses more frequently***, perform the additional sensitivity testing necessary to truly own your risk, and have more time for the kinds of informed decision-making that lead to profitable growth.

And it's not only model runs that can be scaled across dozens of cores. Large data imports can also be distributed, dramatically reducing the amount of time spent getting your data into the software. Further performance improvements are made possible through streamlined exposure and loss database schemas, which simplify loss analysis, portfolio management, and reporting, all while reducing the database footprints.

AIR is also committed to giving you the tools and the knowledge to customize how Touchstone is incorporated into your enterprise. With Touchstone application programming interfaces (APIs), you can leverage the varied functions within Touchstone's analysis modules and integrate them with your existing systems through custom-tailored, desktop, browser, or mobile-based solutions. Build superior risk management systems that align with your workflows.

A TRULY OPEN AND FLEXIBLE PLATFORM

With Touchstone, you can seamlessly integrate non-AIR hazard data and models, or your own custom view of risk.

AIR has already signed agreements with a diverse group of companies that provide inland flood hazard maps, earthquake and wind footprints, and terrorism target data, among others. We've also completed integration of ERN's Mexico earthquake and hydro models. Additional

(continued on page 7)

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THE VISION

The benefits of Touchstone today are numerous and profound. But they're just the beginning. We're building Touchstone to be the platform on which you can build a broad analytics infrastructure.

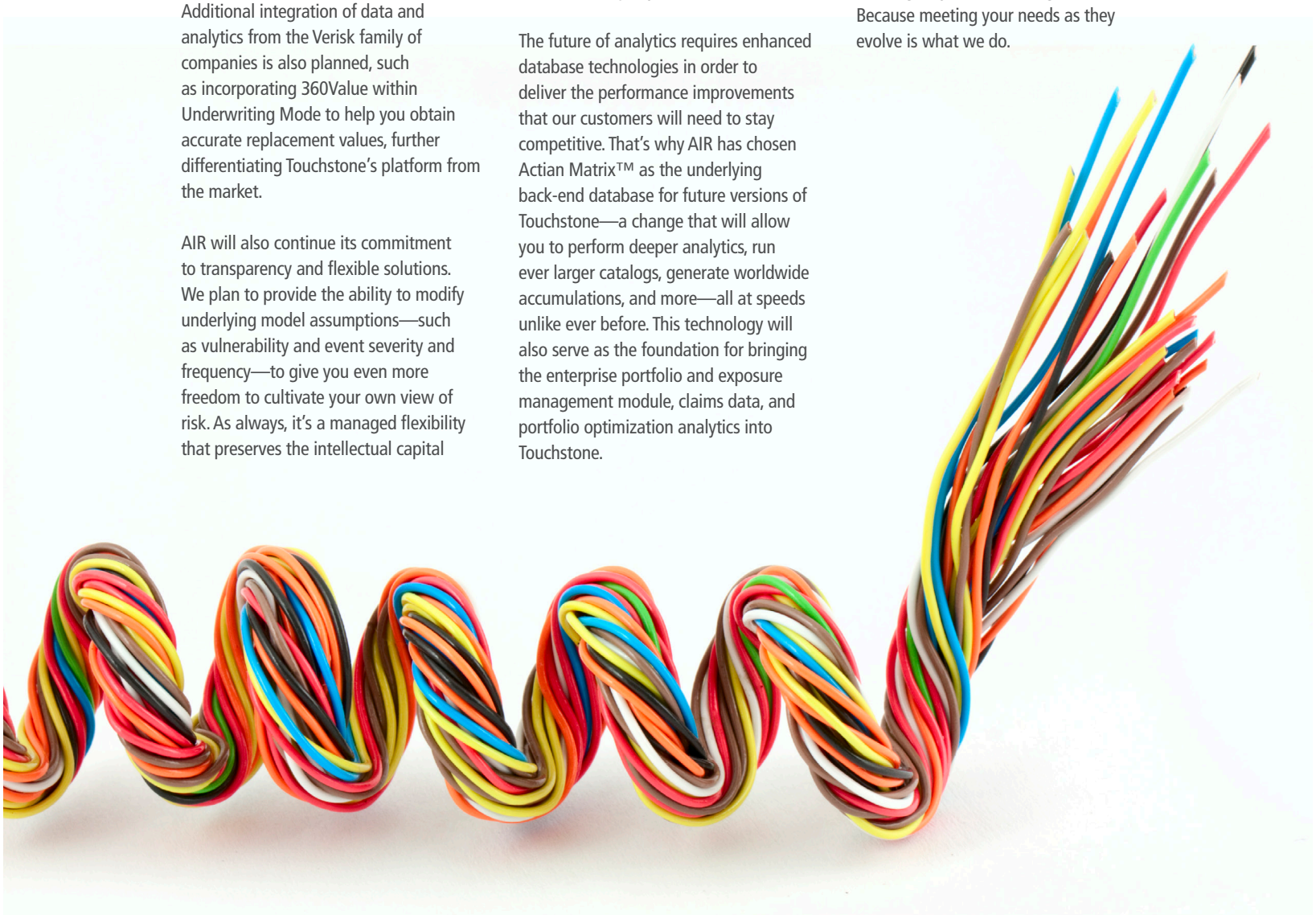
Coming soon, Touchstone will expand its comparative analytics capabilities to allow comparisons between different sets of exposure data or hazard and geospatial results.

Additional integration of data and analytics from the Verisk family of companies is also planned, such as incorporating 360Value within Underwriting Mode to help you obtain accurate replacement values, further differentiating Touchstone's platform from the market.

AIR will also continue its commitment to transparency and flexible solutions. We plan to provide the ability to modify underlying model assumptions—such as vulnerability and event severity and frequency—to give you even more freedom to cultivate your own view of risk. As always, it's a managed flexibility that preserves the intellectual capital behind the AIR models—and you'll never lose sight of the AIR view. Touchstone will also provide a seamless approach to integrating your own in-house models or loss curves and blending the output with AIR and third-party results.

The future of analytics requires enhanced database technologies in order to deliver the performance improvements that our customers will need to stay competitive. That's why AIR has chosen Actian Matrix™ as the underlying back-end database for future versions of Touchstone—a change that will allow you to perform deeper analytics, run ever larger catalogs, generate worldwide accumulations, and more—all at speeds unlike ever before. This technology will also serve as the foundation for bringing the enterprise portfolio and exposure management module, claims data, and portfolio optimization analytics into Touchstone.

Today, Touchstone provides the flexibility, transparency, and performance you need for managing catastrophe risk in the current business environment. Tomorrow, Touchstone will be the holistic solution for meeting all your risk management needs. Because meeting your needs as they evolve is what we do.



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(continued from page 5)

third-party partners include Ambiental (whose map is on page 5), EuroTempest, GEM, IHS Inc., JBA, KatRisk, Met Office, PERILS, Risk Frontiers, SSBN, University of Exeter, and University of Reading. Touchstone's open architecture allows insurers and reinsurers to manage their global exposures and catastrophe risk—including non-modeled risk—in a single platform.

Touchstone also provides the ability to modify modeled losses to match your claims experience and risk appetite, account for non-modeled risk or new scientific findings, or test the sensitivity of event parameters and model assumptions.

TRANSLATING NUMBERS TO PRUDENT—AND PROFITABLE—DECISIONS

Catastrophe modeling was founded on the principle that managing the risk from low-frequency, high-severity events could be undertaken systematically and scientifically. Since then, AIR has been using the most advanced science and engineering to represent our best view of catastrophe loss potential, while catastrophe models have become ever more detailed and sophisticated.

Yet there will never be a single metric or number that provides all the answers to your risk management needs. Knowledge will always remain imperfect, risk appetites and market conditions will continue to change, and unexpected large-loss catastrophes will continue to occur. Instead of fearing uncertainty, Touchstone helps you embrace it, incorporate it into your decision-making, and turn uncertainty into a competitive advantage.

Your business thrives on your own unique experiences and insights. Instead of boxing you in, Touchstone gives you the power and flexibility to truly own the risk and make confident—and profitable—decisions.

KEY BENEFITS

- ✔ Run more analytics in significantly less time to better understand and optimize risk
- ✔ Assess and improve the quality of your exposure data
- ✔ Develop a comprehensive understanding of exposure accumulations
- ✔ Gain insights on the drivers of loss with direct access to hazard information on simulated events
- ✔ Rapidly execute hypothesis and sensitivity testing, including marginal impact analysis
- ✔ More effectively and accurately model advanced insurance/reinsurance terms
- ✔ Leverage award-winning geospatial analytics to understand the relationships between exposure, loss, and hazard
- ✔ Integrate analytics seamlessly into back-end rollup and reporting systems for real-time portfolio management
- ✔ Quickly export maps, charts, and tables into customized reports
- ✔ Select optimal deployment option based on company organization, infrastructure, and needs

Own the risk.

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ABOUT AIR WORLDWIDE

AIR Worldwide (AIR) is the scientific leader and most respected provider of risk modeling software and consulting services. AIR founded the catastrophe modeling industry in 1987 and today models the risk from natural catastrophes and terrorism in more than 90 countries. More than 400 insurance, reinsurance, financial, corporate, and government clients rely on AIR software and services for catastrophe risk management, insurance-linked securities, detailed site-specific wind and seismic engineering analyses, and agricultural risk management. AIR, a Verisk Analytics (Nasdaq:VRSK) business, is headquartered in Boston with additional offices in North America, Europe, and Asia. For more information, please visit www.air-worldwide.com.

AIR WORLDWIDE®

Verisk Analytics®

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Payment Events	Status	Timestamps

Electronic Record and Signature Disclosure

Your Consent to Use Electronic Records and Signatures
From time to time, the Southwest Florida Water Management District (â€œDistrictâ€?) may provide you with certain agreements. The federal E-SIGN Act and the Florida Uniform Electronic Transaction Act, Chapter 668, Florida Statutes, allow the District to provide you these agreements electronically and the use of electronic signatures with your consent. Described below are the terms and conditions for providing you such agreements electronically as well as for the use of electronic signatures. This consent relates to your agreement with the District and any associated electronic signatures. If you consent to receive your agreement electronically and to use electronic signatures, you must keep your email address up to date by notifying ESignQuestions at ESignQuestions@swfwmd.state.fl.usof any changes to your contact information.

Please read the information below thoroughly and, if you can access this information electronically to your satisfaction, please confirm your acceptance and understanding that your electronic signature executed in conjunction with the electronic submission of your agreement shall be legally binding and such transaction shall be considered authorized by you by clicking the â€œI consent to use Electronic Records and Signaturesâ€? box located on the previous page. If you do not agree to use electronic signatures, click the link under â€œOther Optionsâ€? to print and sign the agreement.

Right to Have Records Provided on Paper
At any time, you may request from the District paper copies of any of your agreements at no cost to you. You may request delivery of paper copies by contacting ESignQuestionsat ESignQuestions@swfwmd.state.fl.us. Additionally, following your signing session, you will have the ability to download and print your agreement through the DocuSign, Inc. (â€œDocuSignâ€?) system. You will receive an email with a link to access your agreement within the DocuSign system.

Right to Withdraw Your Consent to Receive Electronic Records; Consequences
If you agree to receive your agreement electronically and use electronic signatures, you have the right to withdraw your consent at any time and at no cost to you. You must inform the District of your decision by ESignQuestions at Â ESignQuestions@swfwmd.state.fl.us. Please include your contact information and the agreement number you are declining to sign electronically in your withdrawal notice. If you elect to receive your agreement only in paper format, or refuse to sign electronically, it may slow down the speed at which you receive documents or information.

Hardware and Software Minimum Requirements
To access and retain your agreement, you will need the following:

Operating Systems:	Windows 2000 or Windows XP
Browsers (for SENDERS):	Internet Explorer 6.0 or above
Browsers (for SIGNERS):	Internet Explorer 6.0, Mozilla Firefox 1.0, NetScape 7.2 (or above)
Email:	Access to a valid email account

Screen Resolution:	800 x 600 minimum
Enable Security Settings:	Allow per session cookies Users accessing internet behind a Proxy Server must enable HTTP 1.1 settings via proxy connection

These minimum requirements are subject to change. If these requirements change such that you may not be able to access or retain the electronic records, we will provide you with an email message at the email address we have on file for you, providing you with the revised hardware and software requirements. At that time, you will have the right to withdraw your consent to receive documents electronically.