CONTRACT RESULTING FROM REQUEST FOR PROPOSAL NUMBER 10090182-25-G, COBRA and Flexible Spending Account (FSA) Administration Services

This Contract (Contract) is entered into by and between the City of San Diego, a municipal corporation (City), and the successful proposer to Request for Proposal (RFP) # 10090182-25-G, COBRA and Flexible Spending Account (FSA) Administration Services (Contractor).

RECITALS

On or about 7/2/2024, City issued an RFP to prospective proposers on services to be provided to the City. The RFP and any addenda and exhibits thereto are collectively referred to as the "RFP." The RFP is attached hereto as Exhibit A.

City has determined that Contractor has the expertise, experience, and personnel necessary to provide the COBRA and Flexible Spending Account (FSA) Administration.

City wishes to retain Contractor to provide a fully insured medical plan as further described in the Scope of Work, attached hereto as Exhibit B. (COBRA and FSA Administration Services).

For good and valuable consideration, the sufficiency of which is acknowledged, City and Contractor agree as follows:

ARTICLE I
CONTRACTOR SERVICES

1.1 Scope of Work. Contractor shall provide the COBRA and FSA Administration Services to City as described in Exhibit B which is incorporated herein by reference. Contractor will submit all required forms and information described in Exhibit A to the Purchasing Agent before providing COBRA and FSA Administration Services.

1.2 General Contract Terms and Provisions. This Contract incorporates by reference the General Contract Terms and Provisions, attached hereto as Exhibit D.

1.3 Contract Administrator. The Risk Management Department (Department) is the Contract Administrator for this Agreement. Contractor shall provide the Services under the direction of a designated representative of the Department as follows:

Quennelle Allen, Deputy Director
Risk Management
1200 Third Avenue, Suite 1000
San Diego, CA 92101
619-236-6185
qallen@sandiego.gov

ARTICLE II
DURATION OF CONTRACT

2.1 Term. This Contract shall be for a period of five (5) years with five (5) one-year options to renew beginning on the Effective Date. The term of this Contract shall not exceed five years unless approved by the City Council by ordinance.

2.2 Effective Date. This Contract shall be effective on January 1, 2025, and approved by the City Attorney in accordance with San Diego Charter Section 40.

ARTICLE III
COMPENSATION

3.1 Amount of Compensation. City shall pay Contractor for performance of all Services rendered in accordance with this Contract in an amount not to exceed $850,000.00.

ARTICLE IV
WAGE REQUIREMENTS

4.1 Reserved.

ARTICLE V
CONTRACT DOCUMENTS

5.1 Contract Documents. The following documents comprise the Contract between the City and Contractor: this Contract and all exhibits thereto, the RFP; Vendors proposal, the Notice to Proceed; and the City's written acceptance of exceptions or clarifications to the RFP, if any.

5.2 Contract Interpretation. The Contract Documents completely describe the COBRA and FSA Administration Services to be provided. Contractor will provide any COBRA and FSA Administration Services that may reasonably be inferred from the Contract Documents or from prevailing custom or trade usage as being required to produce the intended result whether or not specifically called for or identified in the Contract Documents. Words or phrases which have a well-known technical or construction industry or trade meaning and are used to describe COBRA and FSA Administration Services will be interpreted in accordance with that meaning unless a definition has been provided in the Contract Documents.

5.3 Precedence. In resolving conflicts resulting from errors or discrepancies in any of the Contract Documents, the Parties will use the order of precedence as set forth below. The 1st document has the highest priority. Inconsistent provisions in the Contract Documents that address the same subject, are consistent, and have different degrees of specificity, are not in conflict and the more specific language will control. The order of precedence from highest to lowest is as follows:

1st Any properly executed written amendment to the Contract

2nd The Contract

3rd The RFP and the City's written acceptance of any exceptions or clarifications to the RFP, if any

4th Contractor's Pricing

(Remainder of page left blank intentionally.)

5.4 Counterparts. This Contract may be executed in counterparts which, when taken together, shall constitute a single signed original as though all Parties had executed the same page.

5.5 Public Agencies. Other public agencies, as defined by California Government Code section 6500, may choose to use the terms of this Contract, subject to Contractor's acceptance. The City is not liable or responsible for any obligations related to a subsequent Contract between Contractor and another public agency.

IN WITNESS WHEREOF, this Contract is executed by City and Contractor acting by and through their authorized officers.

CONTRACTOR

HealthEquity, Inc.
Proposer

15 W. Scenic Pointe Drive
Street Address

Draper, UT 84020
City

FSA 855.428.0447 COBRA 888.678.4861
Telephone No.

EmployerServices@HealthEquity.com
E-Mail

BY: Signed by: Michael Fiore' 6270E8BB4A2C46B...
Signature of Proposer's Authorized Representative

Michael Fiore
Print Name

EVP & CCO
Title

12/30/2024
Date

CITY OF SAN DIEGO
A Municipal Corporation

BY: CAbarca

Print Name:
Claudia Abarca
Director, Purchasing & Contracting Department

Dec 31, 2024
Date Signed

Approved as to form this _____ day of

_____, 20_____.
MARA W. ELLIOTT, City Attorney

BY: Thomas J. Brady (Dec 31, 2024 12:52 MST)
Deputy City Attorney

The City of SAN DIEGO

Purchasing & Contracting Department

December 19, 2024

VIA EMAIL TO: lfeinstein@healthequity.com

Mr. Louis Feinstein, Sr. Service Delivery Manager
HealthEquity, Inc.
121 W. Scenic Pointe Drive
Draper, UT 84020

Reference: Request for Proposal (RFP) 10090182-24-G, COBRA and Flexible Spending Account (FSA)

Dear Mr. Feinstein:

Subject: Exceptions and Clarifications

This letter confirms our agreement to modify certain terms of the Contract relating to the above-referenced solicitation. Any exception not specifically addressed below is deemed rejected. In addition, the Parties agree as follows:

1. **Exception Requested by Consultant:** The City of San Diego CONTRACT RESULTING FROM REQUEST FOR PROPOSAL NUMBER 10090182-25-G, COBRA and Flexible Spending Account (FSA) Administration Services, Article I, Contractor Services, Section 1.2 General Contract Terms and Provisions shall be **modified** to the following:

   1.2 General Contract Terms and Provisions. The General Contract Terms and Provisions are specifically subject to the exceptions to Exhibit D set forth in this Exception Document below.

   City's Response: Accepted.

2. **Exception Requested by Consultant:** The City of San Diego CONTRACT RESULTING FROM REQUEST FOR PROPOSAL NUMBER 10090182-25-G, COBRA and Flexible Spending Account (FSA) Administration Services, Article II, Duration of Contract, Section 2.1 Terms shall be **modified** to the following:

   2.1 Terms. City Response: Agree to five-year term with removal of unilateral extension.

   City's Response: Accepted.

3. **Exception Requested by Consultant:** The City of San Diego CONTRACT RESULTING FROM REQUEST FOR PROPOSAL NUMBER 10090182-25-G, COBRA and Flexible

Spending Account (FSA) Administration Services, Article III, Compensation shall be **modified** to the following:

3.1 Amount of Compensation. City shall pay Contractor for performance of all Services rendered in accordance with this Contract in an amount not to exceed $850,000.00. Notwithstanding anything contained to the contrary herein, in the event the fees paid by the City hits the not-to-exceed amount before the end of the Contract, Contractor may immediately suspend services without penalty of any kind and without being deemed in default of the contract until an agreement is reached between the parties to increase the not-to-exceed amount. For clarity, under no circumstances shall Contractor be required to continue to perform under the Contract if the City does not have the ability to remain current on all fees and funding as such amounts become due.

City's Response: Accepted.

4. **Exception Requested by Consultant:** The City of San Diego CONTRACT RESULTING FROM REQUEST FOR PROPOSAL NUMBER 10090182-25-G, COBRA and Flexible Spending Account (FSA) Administration Services, Article V, Contract Documents, Section 5.1 Contract Documents shall be **modified** to the following:

Contract Documents. The following documents comprise the Contract between the City and Contractor: this Contract and all exhibits thereto, the RFP; Vendors proposal, the Notice to Proceed; and the City's written acceptance of exceptions or clarifications to the RFP, if any. For clarity, notwithstanding anything contained to the contrary herein, in the event the City does not accept all exceptions or clarifications to the RFP that is submitted herein, this Contract shall be null and void and of no force and effect unless Contractor and City mutually agree otherwise. (2) For clarity, notwithstanding anything contained herein to the contrary, Exhibits E and F, submitted as part of the Scope of Services, shall also be part of the Contract.

City's Response: Accepted.

5. **Exception Requested by Consultant:** Exhibit A, The City of San Diego PROPOSAL SUBMISSION AND REQUIREMENTS, Section A. Proposal Submission, Sub-Section 2.1 shall be **modified** to the following:

2.1 Completed and signed Contract Signature Page. If any addenda are issued, the latest Addendum Contract Signature Page is required.

City's Response: Accepted.

6. **Exception Requested by Consultant:** Exhibit A, The City of San Diego PROPOSAL SUBMISSION AND REQUIREMENTS, Section A. Proposal Submission, Sub-Section 10. Right to Audit shall be **modified** to the following:

10. Right to Audit. The City Auditor may access proposer's records as described in San Diego Charter section 39.2 to confirm contract compliance. Notwithstanding anything contrary in San Diego Charter section 39.2, audit shall be limited to no more than once

per year, subject to a mutually agreed upon scope, and conducted at mutually agreed upon times and dates.

City's Response: Accepted.

7. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article I Scope and Term of Contract, Section 1.1. Scope of Contract shall be **modified** to the following:

1.1 Scope of Contract. The scope of contract between the City and a provider of goods and/or services (Contractor) is described in the Contract Documents. The Contract Documents are comprised of the Request for Proposal, Invitation to Bid, or other solicitation document (Solicitation); the successful bid or proposal; the letter awarding the contract to Contractor; the City's written acceptance of exceptions or clarifications to the Solicitation, if any; and these General Contract Terms and Provisions. For clarity, notwithstanding anything contained to the contrary herein, in the event the City does not accept all exceptions or clarifications to the RFP that is submitted herein, there shall be no Contract unless Contractor and City mutually agree otherwise.

City's Response: Accepted.

8. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article I Scope and Term of Contract, Section 1.3. Contract Extension shall be **deleted** in its entirety.

City's Response: Accepted.

9. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article I Scope and Term of Contract, Section 3.2 Invoices shall be **modified** to the following:

3.2 Invoices. Contractor shall invoice the City for all amounts due under this Agreement on a monthly basis. Payment for invoices shall be due and payable by City within 30 days of receipt. City shall pay the invoices by one of the following methods: check, Wire/ACH Credit or ACH Debit. If City chooses ACH Debit as the payment method, Employer shall provide the banking information as of the Effective Date.

City's Response: Accepted.

10. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article I Scope and Term of Contract, **Section 4.1 City's Right to Suspend for Convenience** shall be **deleted** in its entirety.

City's Response: Accepted.

11. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract

Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article I Scope and Term of Contract, Section 4.2 City's Right to Terminate for Convenience shall be **modified** to the following:

4.2 City's Right to Terminate for Convenience. City may, at its sole option and for its convenience, terminate all or any portion of this Contract by giving thirty (30) days' written notice of such termination to Contractor. The termination of the Contract shall be effective upon receipt of the notice by Contractor. After termination of all or any portion of the Contract, Contractor shall: (1) immediately discontinue all affected performance (unless the notice directs otherwise); and (2) complete any and all additional work necessary for the orderly filing of documents and closing of Contractor's affected performance under the Contract. After filing of documents and completion of performance, Contractor shall make available to the City a portal to download documents and data in its system that are used in the provision of services at no cost to the City. To the extent the City is seeking other documents and data not stored in the Contractor's system, Contractor will deliver to City all such other data, drawings, specifications, reports, estimates, summaries, and such other information and materials created or received by Contractor in performing this Contract, whether completed or in process, the cost and expense of which shall be fully borne by the City. By accepting payment for completion, filing, and delivering documents as called for in this section, Contractor discharges City of all of City's payment obligations and liabilities under this Contract with regard to the affected performance.

City's Response: Accepted.

12. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article I Scope and Term of Contract, Section City's Right to Terminate for Default., Subsection 4.3.2 shall be **deleted** in its entirety.

City's Response: Accepted.

13. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article V Additional Contractor Obligations Subsections 5.1 through 5.7 shall be **deleted** in their entirety.

City's Response: Accepted.

14. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article V Additional Contractor Obligations, 5.9 shall be **modified** to the following:

5.9 Records Retention and Examination. Contractor shall retain, protect, and maintain all records and documents, including paper, electronic, and computer records, relating to this Contract for five (5) years after receipt of final payment by City under this Contract or as otherwise required by law or the Contractors record retention policy.

City's Response: Accepted.

15. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article V Additional Contractor Obligations, Section 5.9.1 shall be **deleted** in their entirety.

    City's Response: Accepted.

16. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article V Additional Contractor Obligations, Section 5.11 Duty to Cooperate with Auditor shall be **modified** to the following:

    Section 5.11 Duty to Cooperate with Auditor. The City Auditor may, in his sole discretion, at no cost to the City, and for purposes of performing his responsibilities under Charter section 39.2, review Contractor's records to confirm contract compliance. Contractor shall make reasonable efforts to cooperate with Auditor's requests. Notwithstanding anything contained to the contrary herein, the City shall be responsible for its own costs associated with any audit. In addition, all audits shall be limited to no more than once per year, subject to a mutually agreed upon scope, and conducted at mutually agreed upon times and dates.

    City's Response: Accepted.

17. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article V Additional Contractor Obligations, Section 5.12 Safety Data Sheets shall be **deleted** in their entirety.

    City's Response: Accepted.

18. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article V Additional Contractor Obligations, Section 5.13.1 Criminal Background Certification shall be **modified** to the following:

    5.13.1 Criminal Background Certification. Contractor certifies that all employees working on this Contract have had a criminal background check and that said employees are clear of any sexual and drug related convictions. Contractor further certifies that all employees hired by Contractor, or a subcontractor shall be free from any felony convictions. Notwithstanding anything contained to the contrary contained herein, all criminal background checks are performed in accordance with Contractor's policies, and all determinations related to the hiring of personnel are in accordance with those policies and as required by applicable law.

    City's Response: Accepted.

19. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article V Additional Contractor Obligations, Section 5.16 Contractor and Subcontractor

Registration Requirements shall be **modified** to the following:

5.16 Contractor and Subcontractor Registration Requirements. Prior to the award of the Contract or Task Order, Contractor and Contractor's subcontractors and suppliers must register with the City's web-based vendor registration and bid management system. The City may not award the Contract until registration of all subcontractors and suppliers is complete. In the event this requirement is not met within the time frame specified by the City, the City reserves the right to rescind the Contract award and to make the award to the next responsive and responsible proposer of bidder. Notwithstanding anything contained to the contrary contained herein, this provision shall not apply to Subcontractors.

City's Response: Accepted.

20. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article VI Intellectual Property Rights, 6.1 Rights in Data shall be **modified** to the following:

6.1 Rights in Data. If, in connection with the services performed under this Contract, Contractor , including its employees, agents, and subcontractors, may not use any of the City's intellectual property for purposes unrelated to the Contractor's work on behalf of the City without prior written consent of the City. Contractor may not publish or reproduce any intellectual property, for purposes unrelated to Contractor's work on behalf of the City, without prior written consent of the City.

City's Response: Accepted.

21. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article VI Intellectual Property Rights, 6.2 Intellectual Property Rights Assignment shall be **deleted** in their entirety.

City's Response: Accepted.

22. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article VI Intellectual Property Rights, 6.4 Subcontracting shall be **deleted** in their entirety.

City's Response: Accepted.

23. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article VI Intellectual Property Rights, 6.5 Intellectual Property Warranty and Indemnification shall be **deleted** in their entirety.

City's Response: Accepted.

24. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article VI Intellectual Property Rights, 6.6 Software Licensing shall be **modified** to the following:

6.6 Software Licensing. Contractor represents and warrants that Contractor's websites, if any, as used by the City or its employees, is designed and monitored not to contain any program code, virus, worm, trap door, back door, time or clock that would erase data or programming or otherwise cause users equipment to become inoperable, inaccessible, or incapable of being used. Contractor further represents and warrants that all third-party software, used by Contractor in the performance of the Contract, is fully licensed by the appropriate licensor.

City's Response: Accepted.

25. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article VII Indemnification and Insurance, 7.1 Indemnification and Limitation of Liability shall be **modified** to the following:

7.1 Indemnification and Limitation of Liability. Contractor shall defend, indemnify and hold harmless and its elected officials, officers, employees, agents, and representatives (Indemnified Parties) from and against all claims, liabilities, losses, damages and expenses, including attorneys' fees (collectively "Losses") asserted by any party who is not a party to this Agreement to the extent caused by Contractor's breach of this Agreement, negligence or willful misconduct; provided, however, that Contractor shall not defend, indemnify or hold the Indemnified Parties harmless for Losses, in each case to the extent arising out of the City's breach of this Agreement, acts, omissions, negligence, or willful misconduct. Indemnified Parties shall give the Contractor written notice of each claim, if any, promptly after the Indemnified Parties' first knowledge thereof. The Contractor may direct the defense of its interests; provided, however, the Indemnified Parties are entitled to retain counsel to provide for its own defense unless or until provided reasonable notice by the Contractor of its intent to direct the defense." The title of this provision should be modified to: "Indemnification and Limitation of Liability." An additional paragraph should be added as follows: "Limitation of Liability. Except for damages incurred or arising out of or due to gross negligence, willful misconduct or fraud of the other Party, the aggregate liability of either Party to the other Party from any and all actions relating to the subject matter of this Agreement shall not exceed fees actually paid by Employer to HQY under this Agreement in the twelve months preceding the date on which the cause of action arose. NEITHER PARTY SHALL BE LIABLE FOR ANY INDIRECT, SPECIAL, INCIDENTAL OR CONSEQUENTIAL DAMAGES OF ANY KIND, EVEN IN THE EVENT THAT IT IS ADVISED OF THE POSSIBILITY THAT SUCH DAMAGE MAY ARISE, OCCUR OR RESULT.

City's Response: Accepted.

26. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article

VII Indemnification and Insurance, 7.2 Insurance shall be **modified** to the following:

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

City's Response: Accepted.

27. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article VII Indemnification and Insurance, 7.2.5.1 Additional Insured Status shall be **modified** to the following:

7.2.5.1 Additional Insured Status. The City, its officers, officials, employees, and volunteers are to be listed as additional insureds on the Certificate of Insurance.

City's Response: Accepted.

28. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article VII Indemnification and Insurance, 7.2.5.3 Notice of Cancellation shall be **modified** to the following:

7.2.5.3 Notice of Cancellation. Notice of cancellation shall be provided in accordance with the terms of the policies.

City's Response: Accepted.

29. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article VII Indemnification and Insurance, 7.2.5.5 Claims Made Policies shall be **modified** to the following:

7.2.5.5 Claims Made Policies (applicable only to professional liability). The Retroactive Date must be shown and must be before the date of the contract or the beginning of contract work. Insurance must be maintained, and evidence of insurance must be provided for at least three (3) years after completion of the contract of work. If coverage is canceled or nonrenewed, and not replaced with another claims-made policy form with a Retroactive Date prior to the contract effective date, Contractor must purchase "extended reporting" coverage for a minimum of three (3) years after completion of work.

City's Response: Accepted.

30. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article VII Indemnification and Insurance, 7.3 Self Insured Retentions shall be **modified** to the following:

7.3 Self Insured Retentions. Self-insured retentions must be declared to the City. Contractor agrees to provide audited financial statements to the City.

City's Response: Accepted.

31. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article VII Indemnification and Insurance, 7.5 Verification of Coverage shall be **modified** to the following:

    7.5 Verification of Coverage. Contractor shall furnish City with original certificates effecting coverage required by this clause. All certificates are to be received and approved by City before work commences. However, failure to obtain the required documents prior to the work beginning shall not waive Contractor's obligation to provide them.

    City's Response: Accepted.

32. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article VII Indemnification and Insurance, 7.6 Special Risks or Circumstances shall be **modified** to the following:

    7.6 Special Risks or Circumstances. City reserves the right to request to modify these requirements, including limits, based on the nature of the risk, prior experience, insurer, coverage, or other special circumstances. All modifications must be mutually agreed to.

    City's Response: Accepted.

33. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article VII Indemnification and Insurance, 7.9 Subcontractors shall be **modified** to the following:

    7.9 Subcontractors. Contractor will request all subcontractors performing work in connection with this Agreement to maintain insurance coverage and limits usual and customary for the product or service provided.

    City's Response: Accepted.

34. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article VIII Bonds shall be deleted in its entirety.

    City's Response: Accepted.

35. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article

IX City-Mandated Clauses and Requirements, 9.1.2 Contractor Certification for Americans with Disabilities Act (ADA) and State Access Laws and Regulations shall be **modified** to the following:

9.1.2 Contractor Certification for Americans with Disabilities Act (ADA) and State Access Laws and Regulations. Contractor shall use best efforts to comply with all accessibility requirements under the ADA and under Title 24 of the California Code of Regulations (Title 24). When a conflict exists between the ADA and Title 24, Contractor shall use best efforts to comply with the most restrictive requirement (i.e., that which provides the most access).

City's Response: Accepted.

36. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article IX City-Mandated Clauses and Requirements, 9.1.3.3 Compliance Investigations shall be **modified** to the following:

    9.1.3.3 Compliance Investigations. Upon City's request, Contractor agrees to provide to City, within sixty calendar days, a truthful and complete list of the names of all subcontractors that Contractor has used to provide services under this contract during the term of this contract. Contractor further agrees to reasonably cooperate in any investigation conducted by City pursuant to City's Nondiscrimination in Contracting Ordinance. Contractor understands and agrees that violation of this clause shall be considered a material breach of the Contract and may result in Contract termination, debarment, and other sanctions.

    City's Response: Accepted.

36. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article IX City-Mandated Clauses and Requirements, 9.1.6 Noise Abatement shall be **deleted** in its entirety.

    City's Response: Accepted.

37. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article IX City-Mandated Clauses and Requirements, 9.1.7 Storm Water Pollution Prevention Program shall be **deleted** in its entirety.

    City's Response: Accepted.

38. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article IX City-Mandated Clauses and Requirements, 9.1.8 Service Worker Retention Ordinance shall be **deleted** in its entirety.

City's Response: Accepted.

40. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article IX City-Mandated Clauses and Requirements, 9.1.11.1 Contractor and Subcontract Requirement shall be **modified** to the following:

    9.1.11.1 Contractor and Subcontract Requirement. The Equal Pay Ordinance applies to any subcontractor who performs work on behalf of a Contractor.

    City's Response: Accepted.

41. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article IX City-Mandated Clauses and Requirements, 13.2 Non-Assignment shall be **modified** to the following:

    13.2 Non-Assignment. Contractor may assign this Agreement to any affiliate or as part of the sale of all or any portion of its assets, or pursuant to any merger, consolidation or other reorganization, without the City's prior written consent. Otherwise, Contractor may not assign its rights and responsibilities under this Agreement without the prior written consent of the City, which consent shall not be unreasonably withheld, delayed or conditioned.

    City's Response: Accepted.

42. **Exception Requested by Consultant:** Exhibit D, The City of San Diego General Contract Terms and Provisions Applicable to Goods, Services, and Consultants Contracts, Article IX City-Mandated Clauses and Requirements, 13.4 Subcontractors shall be **deleted** in its entirety.

    City's Response: Accepted.

Please indicate your agreement with the above by signing the bottom of this letter. Thank you for your assistance.

Sincerely,

Jerry G. Gibbs
Associate Procurement Contracting Officer

This Letter is executed by the City and Contractor acting by and through their authorized officers.

HEALTHEQUITY, INC.

By: Signed by: Michael Fiore' 6270E8BB4A2C48B...

Name: Michael Fiore

Title: EVP & CCO

Date: 12/30/2024

THE CITY OF SAN DIEGO

By: CA Abarca

Name: Claudia Abarca

Title: Director, Purchasing & Contracting

Date: Dec 31, 2024

EXHIBIT A
PROPOSAL SUBMISSION AND REQUIREMENTS

A. PROPOSAL SUBMISSION

1. Timely Proposal Submittal. Proposals must be submitted as described herein to the Purchasing & Contracting Department (P&C).

1.1 Reserved.

1.2 Paper Proposals. The City will accept paper proposals in lieu of eProposals. Paper proposals must be submitted in a sealed envelope to the Purchasing & Contracting Department (P&C) located at 1200 Third Avenue, Suite 200, San Diego, CA 92101. The Solicitation Number and Closing Date must be referenced in the lower left-hand corner of the outside of the envelope. Faxed proposals will not be accepted.

1.3 Proposal Due Date. Proposals must be submitted prior to the Closing Date indicated on the eBidding System. E-mailed and/or faxed proposals will not be accepted.

1.4 Pre-Proposal Conference. No pre-proposal conference will be held for RFP.

1.4.1 Reserved.

1.5 Questions and Comments. Written questions and comments must be submitted electronically via the eBidding System no later than the date specified on the eBidding System. Only written communications relative to the procurement shall be considered. The City's eBidding System is the only acceptable method for submission of questions. All questions will be answered in writing. The City will distribute questions and answers without identification of the inquirer(s) to all proposers who are on record as having received this RFP, via its eBidding System. No oral communications can be relied upon for this RFP. Addenda will be issued addressing questions or comments that are determined by the City to cause a change to any part of this RFP.

1.6 Contact with City Staff. Unless otherwise authorized herein, proposers who are considering submitting a proposal in response to this RFP, or who submit a proposal in response to this RFP, are prohibited from communicating with City staff about this RFP from the date this RFP is issued until a contract is awarded.

2. Proposal Format and Organization. Unless electronically submitted, all proposals should be securely bound and must include the following completed and executed forms and information presented in the manner indicated below:

Tab A - Submission of Information and Forms.

2.1 Completed and signed Contract Signature Page. If any addenda are issued, the latest Addendum Contract Signature Page is required.

2.2 Exceptions requested by proposer, if any. The proposer must present written factual or legal justification for any exception requested to the Scope of Work, the

Contract, or the Exhibits thereto. Any exceptions to the Contract that have not been accepted by the City in writing are deemed rejected. The City, in its sole discretion, may accept some or all of proposer's exceptions, reject proposer's exceptions, and deem the proposal non-responsive, or award the Contract without proposer's proposed exceptions. The City will not consider exceptions addressed elsewhere in the proposal.

2.3 The Contractor Standards Pledge of Compliance Form.

2.4 Equal Opportunity Contracting forms including the Work Force Report and Contractors Certification of Pending Actions.

2.5 Reserved.

2.6 Reserved.

2.7 Reserved.

2.8 Reserved.

2.9 Reserved.

Tab B - Executive Summary and Responses to Specifications.

2.10 A title page.

2.11 A table of contents.

2.12 An executive summary, limited to one typewritten page, that provides a high-level description of the proposer's ability to meet the requirements of the RFP and the reasons the proposer believes itself to be best qualified to provide the identified services.

2.13 Proposer's response to the RFP.

Tab C - Cost/Price Proposal. Proposers shall submit a cost proposal in the form and format described herein. Failure to provide cost(s) in the form and format requested may result in proposal being declared non-responsive and rejected.

3. Proposal Review. Proposers are responsible for carefully examining the RFP, the Specifications, this Contract, and all documents incorporated into the Contract by reference before submitting a proposal. If selected for award of contract, proposer shall be bound by same unless the City has accepted proposer's exceptions, if any, in writing.

4. Addenda. The City may issue addenda to this RFP as necessary. All addenda are incorporated into the Contract. The proposer is responsible for determining whether addenda were issued prior to a proposal submission. Failure to respond to or properly address addenda may result in rejection of a proposal.

5. Quantities. The estimated quantities provided by the City are not guaranteed. These quantities are listed for informational purposes only. Quantities vary depending on the demands of the City. Any variations from the estimated quantities shall not entitle the proposer to an adjustment in the unit price or any additional compensation.

6. Quality. Unless otherwise required, all goods furnished shall be new and the best of their kind.

6.1 Items Offered. Proposer shall state the applicable trade name, brand, catalog, manufacturer, and/or product number of the required good, if any, in the proposal.

6.2 Brand Names. Any reference to a specific brand name in a solicitation is illustrative only and describes a component best meeting the specific operational, design, performance, maintenance, quality, or reliability standards and requirements of the City. Proposer may offer an equivalent or equal in response to a brand name referenced (Proposed Equivalent). The City may consider the Proposed Equivalent after it is subjected to testing and evaluation which must be completed prior to the award of contract. If the proposer offers an item of a manufacturer or vendor other than that specified, the proposer must identify the maker, brand, quality, manufacturer number, product number, catalog number, or other trade designation. The City has complete discretion in determining if a Proposed Equivalent will satisfy its requirements. It is the proposer's responsibility to provide, at their expense, any product information, test data, or other information or documents the City requests to properly evaluate or demonstrate the acceptability of the Proposed Equivalent, including independent testing, evaluation at qualified test facilities, or destructive testing.

7. Modifications, Withdrawals, or Mistakes. Proposer is responsible for verifying all prices and extensions before submitting a proposal.

7.1 Modification or Withdrawal of Proposal Before Proposal Opening. Prior to the Closing Date, the proposer or proposer's authorized representative may modify or withdraw the proposal by providing written notice of the proposal modification or withdrawal to the City Contact via the eBidding System. E-mail or telephonic withdrawals or modifications are not permissible.

7.2 Proposal Modification or Withdrawal of Proposal After Proposal Opening. Any proposer who seeks to modify or withdraw a proposal because of the proposer's inadvertent computational error affecting the proposal price shall notify the City Contact identified on the eBidding System no later than three working days following the Closing Date. The proposer shall provide worksheets and such other information as may be required by the City to substantiate the claim of inadvertent error. Failure to do so may bar relief and allow the City recourse from the bid surety. The burden is upon the proposer to prove the inadvertent error. If, as a result of a proposal modification, the proposer is no longer the apparent successful proposer, the City will award to the newly established apparent successful proposer. The City's decision is final.

8. Incurred Expenses. The City is not responsible for any expenses incurred by proposers in participating in this solicitation process.

9. Public Records. By submitting a proposal, the proposer acknowledges that any information submitted in response to this RFP is a public record subject to disclosure unless the City determines that a specific exemption in the California Public Records Act (CPRA) applies. If the proposer submits information clearly marked confidential or proprietary, the City may protect such information and treat it with confidentiality to the extent permitted by law. However, it will be the responsibility of the proposer to provide to the City the specific legal grounds on which the City can rely in withholding information requested under the

CPRA should the City choose to withhold such information. General references to sections of the CPRA will not suffice. Rather, the proposer must provide a specific and detailed legal basis, including applicable case law, that clearly establishes the requested information is exempt from the disclosure under the CPRA. If the proposer does not provide a specific and detailed legal basis for requesting the City to withhold proposer's confidential or proprietary information at the time of proposal submittal, City will release the information as required by the CPRA and proposer will hold the City, its elected officials, officers, and employees harmless for release of this information. It will be the proposer's obligation to defend, at proposer's expense, any legal actions or challenges seeking to obtain from the City any information requested under the CPRA withheld by the City at the proposer's request. Furthermore, the proposer shall indemnify and hold harmless the City, its elected officials, officers, and employees from and against any claim or liability, and defend any action brought against the City, resulting from the City's refusal to release information requested under the CPRA which was withheld at proposer's request. Nothing in the Contract resulting from this proposal creates any obligation on the part of the City to notify the proposer or obtain the proposer's approval or consent before releasing information subject to disclosure under the CPRA.

10. Right to Audit. The City Auditor may access proposer's records as described in San Diego Charter section 39.2 to confirm contract compliance.

B. PRICING

1. Fixed Price. All prices shall be firm, fixed, fully burdened, FOB destination, and include any applicable delivery or freight charges, and any other costs required to provide the requirements as specified in this RFP. The lowest total estimated contract price of all the proposals that meet the requirements of this RFP will receive the maximum assigned points to this category as set forth in this RFP. The other price schedules will be scored based on how much higher their total estimated contract prices compare with the lowest:

$$\left(1 - \frac{\text{(contract price - lowest price)}}{\text{lowest price}}\right) \times \text{maximum points} = \text{points received}$$

For example, if the lowest total estimated contract price of all proposals is $100, that proposal would receive the maximum allowable points for the price category. If the total estimated contract price of another proposal is $105 and the maximum allowable points is 60 points, then that proposal would receive (1 – ((105 – 100) / 100) x 60 = 57 points, or 95% of the maximum points. The lowest score a proposal can receive for this category is zero points (the score cannot be a negative number). The City will perform this calculation for each Proposal.

2. Taxes and Fees. Taxes and applicable local, state, and federal regulatory fees should not be included in the price proposal. Applicable taxes and regulatory fees will be added to the net amount invoiced. The City is liable for state, city, and county sales taxes but is exempt from Federal Excise Tax and will furnish exemption certificates upon request. All or any portion of the City sales tax returned to the City will be considered in the evaluation of proposals.

3. Escalation. An escalation factor is not allowed unless called for in this RFP. If escalation is allowed, proposer must notify the City in writing in the event of a decline in

market price(s) below the proposal price. At that time, the City will make an adjustment in the Contract or may elect to re-solicit.

4. Unit Price. Unless the proposer clearly indicates that the price is based on consideration of being awarded the entire lot and that an adjustment to the price was made based on receiving the entire proposal, any difference between the unit price correctly extended and the total price shown for all items shall be offered shall be resolved in favor of the unit price.

C. EVALUATION OF PROPOSALS

1. Award. The City shall evaluate each responsive proposal to determine which proposal offers the City the best value consistent with the evaluation criteria set forth herein. The proposer offering the lowest overall price will not necessarily be awarded a contract.

2. Sustainable Materials. Consistent with Council Policy 100-14, the City encourages use of readily recyclable submittal materials that contain post-consumer recycled content.

3. Evaluation Process.

3.1 Process for Award. A City-designated evaluation committee (Evaluation Committee) will evaluate and score all responsive proposals. The Evaluation Committee may require proposer to provide additional written or oral information to clarify responses. Upon completion of the evaluation process, the Evaluation Committee will recommend to the Purchasing Agent that award be made to the proposer with the highest scoring proposal.

3.2 Reserved.

3.3 Mandatory Interview/Oral Presentation. The City will require proposers to interview and/or make an oral presentation if one or more proposals score within (7) seven points or less of the proposal with the highest score. Only the proposer with the highest scoring proposal and those proposers scoring within (7) seven points or less of the highest scoring proposal will be asked to interview and/or make an oral presentation. Interviews and/or oral presentations will be made to the Evaluation Committee in order to clarify the proposals and to answer any questions. The interviews and/or oral presentations will be scored as part of the selection process. The City will complete all reference checks prior to any oral interview. Additionally, the Evaluation Committee may require proposer's key personnel to interview. Interviews may be by telephone and/or in person. Multiple interviews may be required. Proposers are required to complete their oral presentation and/or interviews within seven (7) workdays after the City's request. Proposers should be prepared to discuss and substantiate any of the areas of the proposal submitted, as well as proposer's qualifications to furnish the subject goods and services. Proposer is responsible for any costs incurred for the oral presentation and interview of the key personnel.

3.4 Discussions/Negotiations. The City has the right to accept the proposal that serves the best interest of the City, as submitted, without discussion or negotiation. Contractors should, therefore, not rely on having a chance to discuss, negotiate, and adjust their proposals. The City may negotiate the terms of a contract with the winning proposer based on the RFP and the proposer's proposal, or award the contract without further negotiation.

3.5 Inspection. The City reserves the right to inspect the proposer's equipment and facilities to determine if the proposer is capable of fulfilling this Contract. Inspection will include, but not limited to, survey of proposer's physical assets and financial capability. Proposer, by signing the proposal agrees to the City's right of access to physical assets and financial records for the sole purpose of determining proposer's capability to perform the Contract. Should the City conduct this inspection, the City reserves the right to disqualify a proposer who does not, in the City's judgment, exhibit the sufficient physical and financial resources to perform this Contract.

3.6 Evaluation Criteria. The following elements represent the evaluation criteria that will be considered during the evaluation process:

	MAXIMUM EVALUATION POINTS
A. Completeness of RFP Response.	**10**
1. Overall quality and completeness of proposal, including all required content in RFP and any subsequent addenda and questionnaire.	
B. Qualifications.	**40**
Proposals will be evaluated against the RFP specifications and the questions below:	
1. Is the bidder including both services (FSA and COBRA)?	
2. Has the bidder demonstrated a thorough understanding of the purpose and scope of both services?	
3. How well has the bidder identified pertinent issues and potential problems related to administration of the program?	
4. Has the bidder demonstrated that it understands the deliverables the City expects to provide?	
5. Security protocols used by the bidder to ensure data security.	
C. Relevant Experience/References.	**25**
Proposal will be evaluated against the RFP specifications and the questions below:	
1. Do the individuals assigned to the project have experience on similar projects/programs?	
2. How extensive is the applicable education and experience of the personnel designated to work on the project?	
3. References.	
4. Exceptions.	
D. Price.	**10**
E. Mandatory Demonstration/Presentation.	**15**
1. Evaluation will be made on likelihood that bidder's implementation plan and schedule will meet the City's needs.	
2. Evaluation of online portals for participants and employer.	
3. Thoroughness and Clarity of Presentation.	

	MAXIMUM EVALUATION POINTS
SUB TOTAL MAXIMUM EVALUATION POINTS:	**100**
F. Participation by Small Local Business Enterprise (SLBE) or Emerging Local Business Enterprise (ELBE) Firms*	**12**
FINAL MAXIMUM EVALUATION POINTS INCLUDING SLBE/ELBE:	**112**

*The City shall apply a maximum of an additional 12 points to the proposer's final score for SLBE OR ELBE participation. Refer to Equal Opportunity Contracting Form, Section V.

4. Rejection of All Proposals. The City may reject any and all proposals when to do so is in the City's best interests.

D. ANNOUNCEMENT OF AWARD

1. Award of Contract. The City will inform all proposers of its intent to award a Contract in writing.

2. Obtaining Proposal Results. No solicitation results can be obtained until the City announces the proposal or proposals best meeting the City's requirements. Proposal results may be obtained by: (1) e-mailing a request to the City Contact identified on the eBidding System or (2) visiting the P&C eBidding System to review the proposal results. To ensure an accurate response, requests should reference the Solicitation Number. Proposal results will not be released over the phone.

3. Multiple Awards. City may award more than one contract by awarding separate items or groups of items to various proposers. Awards will be made for items, or combinations of items, which result in the lowest aggregate price and/or best meet the City's requirements. The additional administrative costs associated with awarding more than one Contract will be considered in the determination.

E. PROTESTS. The City's protest procedures are codified in Chapter 2, Article 2, Division 30 of the San Diego Municipal Code (SDMC). These procedures provide unsuccessful proposers with the opportunity to challenge the City's determination on legal and factual grounds. The City will not consider or otherwise act upon an untimely protest.

F. SUBMITTALS REQUIRED UPON NOTICE TO PROCEED. The successful proposer is required to submit the following documents to P&C **within ten (10) business days** from the date on the Notice to Proceed letter:

1. Insurance Documents. Evidence of all required insurance, including all required endorsements, as specified in Article VII of the General Contract Terms and Provisions.

2. Taxpayer Identification Number. Internal Revenue Service (IRS) regulations require the City to have the correct name, address, and Taxpayer Identification Number (TIN) or Social Security Number (SSN) on file for businesses or persons who provide goods or services to the City. This information is necessary to complete Form 1099 at the end of each

tax year. To comply with IRS regulations, the City requires each Contractor to provide a Form W-9 prior to the award of a Contract.

3. Business Tax Certificate. Unless the City Treasurer determines a business is exempt, all businesses that contract with the City must have a current business tax certificate.

4. Reserved.

5. Reserved.

The City may find the proposer to be non-responsive and award the Contract to the next highest scoring responsible and responsive proposer if the apparent successful proposer fails to timely provide the required information or documents.

EXHIBIT B
SCOPE OF WORK

A. OVERVIEW

The City of San Diego ("The City"), is releasing this Request for Proposal (RFP) to qualified vendors to provide COBRA and FSA Administration services.

B. BACKGROUND

The City of San Diego is committed to providing affordable, comprehensive, and competitive benefit programs to its employees. The City employs over 11,000 Active employees who are eligible for City benefits. The current COBRA and FSA Administration contract with Health Equity will terminate on 12/31/2024. As of May 2024, there were 142 former employees on COBRA and 2,247 enrolled in Health Care and 439 in Dependent Care FSAs.

C. OBJECTIVE

The objective of the RFP is to award the contract to a COBRA and FSA Administrator that will represent the best value and meet the specifications and requirements of this RFP. The new contract must be guaranteed for a minimum of 5-years from the January 1, 2025, effective date and include an option to renew annually for an additional 5-years.

D. COBRA and FSA RFP CORE REQUIREMENTS

1. Bidders shall submit a proposal based on January 1, 2025, effective date.
2. All premium rates must be guaranteed for a minimum of 12 months.
3. All premium rates must be quoted net of commissions.
4. Contract must be guaranteed for a minimum of 5-years with the option to renew for an additional 5-years.

E. RFP ATTACHMENTS INCLUDED

The following information has been included in this RFP:

1. City of San Diego – 2024 Flexible Benefits Booklet (Attachment A)
2. COBRA and FSA Report from Health Equity (Attachment B)

F. PRICING SUBMITTAL

Vendors shall submit their proposal for pricing on the Pricing Worksheet.xls (Exhibit C). Using this format will help ensure consistency in the price evaluation. The "Proposed Pricing" tab is to be completed in full and shall be incorporated herein. The contract to be awarded is inclusive of all fees and costs of operations. No other charges will be considered.

Proposed contract must be guaranteed for a minimum of 5-years from the January 1, 2025, effective date. Your proposed rates should not include any commissions.

In order for a proposal to comply with the requirements of this RFP, it must include the following:

- ☐ Executive summary indicating the name, address, and contact information of the party responsible for this bid that is able to bind the bidding organization for contract purposes. It should also include confirmation that the vendor can provide each of the services (COBRA and FSA administration) requested in this proposal.

- ☐ City required forms (Exhibits A, B, C, D, EOC form, and Contractor Standard Pledge of Compliance)

- ☐ A fully completed COBRA and FSA questionnaire response (Attachment C-2025 COBRA and FSA RFP Questionnaire.xlsx) – Must be submitted in Excel format not PDF

- ☐ Completed Pricing Worksheet.xlsx (Exhibit C) – Must be submitted in Excel format not PDF

- ☐ A sample contract for COBRA and FSA administration services,

Responses that do not include the proposal content requirements identified within this RFP and subsequent Addenda and do not address each of the required items will be considered incomplete, be rated a Fail in the Evaluation Criteria and will receive no further consideration.

G. TECHINICAL REPRESENTATIVE. The Technical Representative for this Contract is identified in the notice of award and is responsible for overseeing and monitoring this Contract.

CITY OF SAN DIEGO
2025 RFP - PRICING WORKSHEET
FSA & COBRA Services & Fees

Exhibit C

Administrative Service	Current Enrollment	Year 1	Year 2	Year 3	Year 4	Year 5
FLEXIBLE SPENDING ACCOUNT						
Flexible Spending Account - Base fee	11,000					
Minimum Monthly Fee		*$250.00*	*$250.00*	*$250.00*	*$250.00*	*$250.00*
Monthly FSA Admin Fee - PEPM One Account	2,247	$2.50 (One fee for both FSA and DCFSA)	$2.50 (One fee for both FSA and DCFSA)	$2.50 (One fee for both FSA and DCFSA)	$2.50 (One fee for both FSA and DCFSA)	$2.50 (One fee for both FSA and DCFSA)
Two Accounts	439	$2.50 (One fee for both FSA and DCFSA)	$2.50 (One fee for both FSA and DCFSA)	$2.50 (One fee for both FSA and DCFSA)	$2.50 (One fee for both FSA and DCFSA)	$2.50 (One fee for both FSA and DCFSA)
Estimated Annual Total		$80,580	$80,580	$80,580	$80,580	$80,580
Additional Fees						
Initial Plan Document		Initial document and SPD are included.	Initial document and SPD are included.	Initial document and SPD are included.	Initial document and SPD are included.	Initial document and SPD are included.
Debit Card		The first 3 cards are included. Additional cards are available for $5.00 per card paid by the member.	The first 3 cards are included. Additional cards are available for $5.00 per card paid by the member.	The first 3 cards are included. Additional cards are available for $5.00 per card paid by the member.	The first 3 cards are included. Additional cards are available for $5.00 per card paid by the member.	The first 3 cards are included. Additional cards are available for $5.00 per card paid by the member.
Implementation Fee		$500	$500	$500	$500	$500
Hourly fee for Custom Reporting-		$150	$150	$150	$150	$150
Standard Reporting		Included.	Included.	Included.	Included.	Included.
Communciation Fee		Electronic materials are included.	Electronic materials are included.	Electronic materials are included.	Electronic materials are included.	Electronic materials are included.
Annual Non-Discrimination Testing		First test is included. Additional testing is available for $600.	First test is included. Additional testing is available for $600.	First test is included. Additional testing is available for $600.	First test is included. Additional testing is available for $600.	First test is included. Additional testing is available for $600.
Cost for various forms & materials		Electronic materials are included.	Electronic materials are included.	Electronic materials are included.	Electronic materials are included.	Electronic materials are included.
Plan Amendments		$250/hr with $500 minimum fee	$250/hr with $500 minimum fee	$250/hr with $500 minimum fee	$250/hr with $500 minimum fee	$250/hr with $500 minimum fee
FSA Total with Recommended Options		$80,580	$80,580	$80,580	$80,580	$80,580
COBRA						
COBRA - Base Fee	11,000					
Current COBRA Members	142					
Monthly COBRA Admin Fee PEPM		$0.45	$0.45	$0.45	$0.45	$0.45
Estimated Annual Total		$46,888	$46,888	$46,888	$46,888	$46,888
Additional Fees - (Noted in bold font if included in total)		$500.00 monthly minimum	$500.00 monthly minimum	$500.00 monthly minimum	$500.00 monthly minimum	$500.00 monthly minimum

CITY OF SAN DIEGO
2025 RFP - PRICING WORKSHEET
FSA & COBRA Services & Fees

Exhibit C

Administrative Service	Current Enrollment	Year 1	Year 2	Year 3	Year 4	Year 5
Take over Fee for Existing COBRA Members		$10 per takeover	$10 per takeover	$10 per takeover	$10 per takeover	$10 per takeover
Implementation Fee		Included.	Included.	Included.	Included.	Included.
HIPAA Special Enrollment/New Hire Notification		$2.60 per notice (optional service)	$2.60 per notice (optional service)	$2.60 per notice (optional service)	$2.60 per notice (optional service)	$2.60 per notice (optional service)
Communications, forms & materials		Electronic materials included.	Electronic materials included.	Electronic materials included.	Electronic materials included.	Electronic materials included.
Qualifying Event Notices		Included.	Included.	Included.	Included.	Included.
New Hire Notices		Included.	Included.	Included.	Included.	Included.
Standard Reports		Included.	Included.	Included.	Included.	Included.
Eligibility File Feed(Per Carrier Per Month)		Standard format included.	Standard format included.	Standard format included.	Standard format included.	Standard format included.
Carrier Premium Remittance Options (assume 5):		$25.00 per carrier payment per month (optional service)	$25.00 per carrier payment per month (optional service)	$25.00 per carrier payment per month (optional service)	$25.00 per carrier payment per month (optional service)	$25.00 per carrier payment per month (optional service)
Women's Health & Cancer Rights Notices		$2.25 per notice (optional service)	$2.25 per notice (optional service)	$2.25 per notice (optional service)	$2.25 per notice (optional service)	$2.25 per notice (optional service)
2% Fee Returned to City		Retained by HealthEquity.	Retained by HealthEquity.	Retained by HealthEquity.	Retained by HealthEquity.	Retained by HealthEquity.
Past Due Notices- assume 5 every other month	5	Included.	Included.	Included.	Included.	Included.
Custom Report Costs		$150 per hour	$150 per hour	$150 per hour	$150 per hour	$150 per hour
Mass Mailing of COBRA Rights notice to all Ees	At Inception	Included.	Included.	Included.	Included.	Included.
Retroactive HIPAA Enrollment or COBRA General Notice		$2.00 per Retroactive HIPAA Special Enrollment notice (optional service) $3.00 per Retroactive COBRA General Rights notice (optional service)	$2.00 per Retroactive HIPAA Special Enrollment notice (optional service) $3.00 per Retroactive COBRA General Rights notice (optional service)	$2.00 per Retroactive HIPAA Special Enrollment notice (optional service) $3.00 per Retroactive COBRA General Rights notice (optional service)	$2.00 per Retroactive HIPAA Special Enrollment notice (optional service) $3.00 per Retroactive COBRA General Rights notice (optional service)	$2.00 per Retroactive HIPAA Special Enrollment notice (optional service) $3.00 per Retroactive COBRA General Rights notice (optional service)

CITY OF SAN DIEGO
2025 RFP - PRICING WORKSHEET
FSA & COBRA Services & Fees

Exhibit C

Administrative Service	Current Enrollment	Year 1	Year 2	Year 3	Year 4	Year 5
Annual Open Enrollment Support:		We offer multiple open enrollment service options to assist clients in updating their COBRA populations of new enrollment offerings. Service options available to clients include: **Partial Service ($8.00 per packet):** This level of service includes updating rates and plans; producing and mailing rate change notices; notifying carriers of new participant enrollments, terminations and/or other changes and providing toll-free participant service assistance. An annual setup fee of $150 applies. **Standard Service ($15.00 per packet):** This level of service includes updating rates and plans; producing open enrollment letters and forms notifying participants of what benefits are available to them along with the applicable rates; processing all returned open enrollment forms; notifying carriers of new enrollments, terminations, and other changes; and providing toll-free participant service assistance. We will produce and mail participant open enrollment notice and election form packages, up to seven sheets of paper (double sided). An annual setup fee of $150 applies. **Custom Service ($22.00 per packet):** This level of service includes updating rates and plans; producing open enrollment letters and forms notifying participants of what benefits are available to them along with the applicable rates; processing all returned open enrollment forms; notifying carriers of new enrollments, terminations, and other changes; and providing toll-free participant service assistance. We will produce and mail participant open enrollment notice and election form packages, up to 30 sheets of paper (double sided). Special handling for division-based communications and/or custom inserts. An annual setup fee of $150 applies.				
COBRA Total with Recommended Options		$10,956	$10,956	$10,956	$10,956	$10,956
Total FSA & COBRA		**$138,424**	**$138,424**	**$138,424**	**$138,424**	**$138,424**
Discount for Bundled Services Total		N/A	N/A	N/A	N/A	**N/A**

CITY OF SAN DIEGO
2025 RFP - PRICING WORKSHEET
FSA & COBRA Services & Fees

Exhibit C

Administrative Service	Current Enrollment	Year 1	Year 2	Year 3	Year 4	Year 5
FSA Service Offering (indicate if included in above or optional fee)						
Number of Days for Claim processing turnaround	HealthEquity processes claims and issues reimbursements daily. We approve claims within two business days of receipt and issue reimbursements within three to five days.					
Debit Cards Issued (Yes/No?)	Yes					
Cost for Replacement Debit Cards:	The first 3 cards are included. Additional cards are available for $5.00 per card paid by the member.					
Claims submittal options if not using debit card	Members can submit claims and required documentation through our website, mobile app, direct mail, or toll-free fax number.					
Claim reimbursement options if not using debit card	HealthEquity offers multiple options for members to access their FSA funds. Healthcare FSA, reimbursement options include: □ Debit card reimbursement at point of service for immediate access to funds □ Member reimbursement issued via preferred method of direct deposit or mailed check □ Direct pay to providers where funds are paid directly from the member account to their designated providers □ Automatic carrier claims payment of out-of-pocket member costs eligible for reimbursement. Payments are made to members via check or direct deposit. Dependent care FSA reimbursement option include: □ Reimbursement issued via preferred method of direct deposit or mailed check □ Direct pay to providers where funds are paid directly from the member account to their designated providers □ Automatic payments from single claim form submitted at the beginning of the plan year					
Plan document provided	Initial document and SPD are included.					
Discrimination testing provided	First test is included. Additional testing is available for $600.					
Method for sending unallocated year end balance to the City:	HealthEquity reviews and returns funds to clients 45 days after run out. Funds are returned via automated clearing house (ACH), if on file, or check. An email is sent to the client notifying them that the review was completed and directing them to the employer portal for additional information. The client is notified of the amount to be returned, less any outstanding fees, along with the method of the return. Funds are returned to the employer between 45 and 60 days after runout.					
Legislative updates for FSAs to the City:	Included.					
Other Fees and Charges not Specified - Describe:	Admin Fees are charged throughout run-out, carry-over and grace periods for all plan years including the last plan year of the contract.					
Other Fees and Charges not Specified - Describe:						
Other Fees and Charges not Specified - Describe:						
COBRA Service Offering						

CITY OF SAN DIEGO
2025 RFP - PRICING WORKSHEET
FSA & COBRA Services & Fees

Exhibit C

Administrative Service	Current Enrollment	Year 1	Year 2	Year 3	Year 4	Year 5
Employee COBRA communications sent by:	If notification of the qualifying event from the employer is via data file transfer, the file is processed within two business days. The election notice is released in accordance with federal regulations, typically within one to two business days. Notifications received from the employer via the website are processed immediately. The election notice is released in accordance with federal regulations, typically within one to two business days.					
Premium payments to vendors for insured plans?	$25.00 per carrier payment per month (optional service)					
Send annual OE information to COBRA members	We offer multiple open enrollment service options to assist clients in updating their COBRA populations of new enrollment offerings. Service options available to clients include: □ Partial Service ($8.00 per packet): This level of service includes updating rates and plans; producing and mailing rate change notices; notifying carriers of new participant enrollments, terminations and/or other changes and providing toll-free participant service assistance. An annual setup fee of $150 applies. □ Standard Service ($15.00 per packet): This level of service includes updating rates and plans; producing open enrollment letters and forms notifying participants of what benefits are available to them along with the applicable rates; processing all returned open enrollment forms; notifying carriers of new enrollments, terminations, and other changes; and providing toll-free participant service assistance. We will produce and mail participant open enrollment notice and election form packages, up to seven sheets of paper (double sided). An annual setup fee of $150 applies. □ Custom Service ($22.00 per packet): This level of service includes updating rates and plans; producing open enrollment letters and forms notifying participants of what benefits are available to them along with the applicable rates; processing all returned open enrollment forms; notifying carriers of new enrollments, terminations, and other changes; and providing toll-free participant service assistance. We will produce and mail participant open enrollment notice and election form packages, up to 30 sheets of paper (double sided). Special handling for division-based communications and/or custom inserts. An annual setup fee of $150 applies.					
Provide routine/timely COBRA legislative updates	Included.					

EXHIBIT D

THE CITY OF SAN DIEGO

GENERAL CONTRACT TERMS AND PROVISIONS

APPLICABLE TO GOODS, SERVICES, AND CONSULTANT CONTRACTS

ARTICLE I
SCOPE AND TERM OF CONTRACT

1.1 Scope of Contract. The scope of contract between the City and a provider of goods and/or services (Contractor) is described in the Contract Documents. The Contract Documents are comprised of the Request for Proposal, Invitation to Bid, or other solicitation document (Solicitation); the successful bid or proposal; the letter awarding the contract to Contractor; the City's written acceptance of exceptions or clarifications to the Solicitation, if any; and these General Contract Terms and Provisions.

1.2 Effective Date. A contract between the City and Contractor (Contract) is effective on the last date that the contract is signed by the parties and approved by the City Attorney in accordance with Charter section 40. Unless otherwise terminated, this Contract is effective until it is completed or as otherwise agreed upon in writing by the parties, whichever is the earliest. A Contract term cannot exceed five (5) years unless approved by the City Council by ordinance.

1.3 Contract Extension. The City may, in its sole discretion, unilaterally exercise an option to extend the Contract as described in the Contract Documents. In addition, the City may, in its sole discretion, unilaterally extend the Contract on a month-to-month basis following contract expiration if authorized under Charter section 99 and the Contract Documents. Contractor shall not increase its pricing in excess of the percentage increase described in the Contract.

ARTICLE II
CONTRACT ADMINISTRATOR

2.1 Contract Administrator. The Purchasing Agent or designee is the Contract Administrator for purposes of this Contract, and has the responsibilities described in this Contract, in the San Diego Charter, and in Chapter 2, Article 2, Divisions 5, 30, and 32.

2.1.1 Contractor Performance Evaluations. The Contract Administrator will evaluate Contractor's performance as often as the Contract Administrator deems necessary throughout the term of the contract. This evaluation will be based on criteria including the quality of goods or services, the timeliness of performance, and adherence to applicable laws, including prevailing wage and living wage. City will provide Contractors who receive an unsatisfactory rating with a copy of the evaluation and an opportunity to respond. City may consider final evaluations, including Contractor's response, in evaluating future proposals and bids for contract award.

2.2 Notices. Unless otherwise specified, in all cases where written notice is required under this Contract, service shall be deemed sufficient if the notice is personally delivered or deposited in the United States mail, with first class postage paid, attention to the Purchasing Agent. Proper notice is effective on the date of personal delivery or five (5) days after deposit in a United States postal mailbox unless provided otherwise in the Contract. Notices to the City shall be sent to:

Purchasing Agent
City of San Diego, Purchasing and Contracting Division
1200 3rd Avenue, Suite 200
San Diego, CA 92101-4195

ARTICLE III
COMPENSATION

3.1 Manner of Payment. Contractor will be paid monthly, in arrears, for goods and/or services provided in accordance with the terms and provisions specified in the Contract.

3.2 Invoices.

3.2.1 Invoice Detail. Contractor's invoice must be on Contractor's stationary with Contractor's name, address, and remittance address if different. Contractor's invoice must have a date, an invoice number, a purchase order number, a description of the goods or services provided, and an amount due.

3.2.2 Service Contracts. Contractor must submit invoices for services to City by the 10th of the month following the month in which Contractor provided services. Invoices must include the address of the location where services were performed and the dates in which services were provided.

3.2.3 Goods Contracts. Contractor must submit invoices for goods to City within seven days of the shipment. Invoices must describe the goods provided.

3.2.4 Parts Contracts. Contractor must submit invoices for parts to City within seven calendar (7) days of the date the parts are shipped. Invoices must include the manufacturer of the part, manufacturer's published list price, percentage discount applied in accordance with Pricing Page(s), the net price to City, and an item description, quantity, and extension.

3.2.5 Extraordinary Work. City will not pay Contractor for extraordinary work unless Contractor receives prior written authorization from the Contract Administrator. Failure to do so will result in payment being withheld for services. If approved, Contractor will include an invoice that describes the work performed and the location where the work was performed, and a copy of the Contract Administrator's written authorization.

3.2.6 Reporting Requirements. Contractor must submit the following reports using the City's web-based contract compliance portal. Incomplete and/or delinquent reports may cause payment delays, non-payment of invoice, or both. For questions, please view the City's online tutorials on how to utilize the City's web-based contract compliance portal.

3.2.6.1 Monthly Employment Utilization Reports. Contractor and Contractor's subcontractors and suppliers must submit Monthly Employment Utilization Reports by the fifth (5th) day of the subsequent month.

3.2.6.2 Monthly Invoicing and Payments. Contractor and Contractor's subcontractors and suppliers must submit Monthly Invoicing and Payment Reports by the fifth (5^{th}) day of the subsequent month.

3.3 Annual Appropriation of Funds. Contractor acknowledges that the Contract term may extend over multiple City fiscal years, and that work and compensation under this Contract is contingent on the City Council appropriating funding for and authorizing such work and compensation for those fiscal years. This Contract may be terminated at the end of the fiscal year for which sufficient funding is not appropriated and authorized. City is not obligated to pay Contractor for any amounts not duly appropriated and authorized by City Council.

3.4 Price Adjustments. Based on Contractor's written request and justification, the City may approve an increase in unit prices on Contractor's pricing pages consistent with the amount requested in the justification in an amount not to exceed the increase in the Consumer Price Index, San Diego Area, for All Urban Customers (CPI-U) as published by the Bureau of Labor Statistics, or 5.0%, whichever is less, during the preceding one year term. If the CPI-U is a negative number, then the unit prices shall not be adjusted for that option year (the unit prices will not be decreased). A negative CPI-U shall be counted against any subsequent increases in the CPI-U when calculating the unit prices for later option years. Contractor must provide such written request and justification no less than sixty days before the date in which City may exercise the option to renew the contract, or sixty days before the anniversary date of the Contract. Justification in support of the written request must include a description of the basis for the adjustment, the proposed effective date and reasons for said date, and the amount of the adjustment requested with documentation to support the requested change (e.g. CPI-U or 5.0%, whichever is less). City's approval of this request must be in writing.

ARTICLE IV
SUSPENSION AND TERMINATION

4.1 City's Right to Suspend for Convenience. City may suspend all or any portion of Contractor's performance under this Contract at its sole option and for its convenience for a reasonable period of time not to exceed six (6) months. City must first give ten (10) days' written notice to Contractor of such suspension. City will pay to Contractor a sum equivalent to the reasonable value of the goods and/or services satisfactorily provided up to the date of suspension. City may rescind the suspension prior to or at six (6) months by providing Contractor with written notice of the rescission, at which time Contractor would be required to resume performance in compliance with the terms and provisions of this Contract. Contractor will be entitled to an extension of time to complete performance under the Contract equal to the length of the suspension unless otherwise agreed to in writing by the Parties.

4.2 City's Right to Terminate for Convenience. City may, at its sole option and for its convenience, terminate all or any portion of this Contract by giving thirty (30) days' written notice of such termination to Contractor. The termination of the Contract shall be effective upon receipt of the notice by Contractor. After termination of all or any portion of the Contract, Contractor shall: (1) immediately discontinue all affected performance (unless the notice directs otherwise); and (2) complete any and all additional work necessary for the orderly filing of

documents and closing of Contractor's affected performance under the Contract. After filing of documents and completion of performance, Contractor shall deliver to City all data, drawings, specifications, reports, estimates, summaries, and such other information and materials created or received by Contractor in performing this Contract, whether completed or in process. By accepting payment for completion, filing, and delivering documents as called for in this section, Contractor discharges City of all of City's payment obligations and liabilities under this Contract with regard to the affected performance.

4.3 City's Right to Terminate for Default. Contractor's failure to satisfactorily perform any obligation required by this Contract constitutes a default. Examples of default include a determination by City that Contractor has: (1) failed to deliver goods and/or perform the services of the required quality or within the time specified; (2) failed to perform any of the obligations of this Contract; and (3) failed to make sufficient progress in performance which may jeopardize full performance.

4.3.1 If Contractor fails to satisfactorily cure a default within ten (10) calendar days of receiving written notice from City specifying the nature of the default, City may immediately cancel and/or terminate this Contract, and terminate each and every right of Contractor, and any person claiming any rights by or through Contractor under this Contract.

4.3.2 If City terminates this Contract, in whole or in part, City may procure, upon such terms and in such manner as the Purchasing Agent may deem appropriate, equivalent goods or services and Contractor shall be liable to City for any excess costs. Contractor shall also continue performance to the extent not terminated.

4.4 Termination for Bankruptcy or Assignment for the Benefit of Creditors. If Contractor files a voluntary petition in bankruptcy, is adjudicated bankrupt, or makes a general assignment for the benefit of creditors, the City may at its option and without further notice to, or demand upon Contractor, terminate this Contract, and terminate each and every right of Contractor, and any person claiming rights by and through Contractor under this Contract.

4.5 Contractor's Right to Payment Following Contract Termination.

4.5.1 Termination for Convenience. If the termination is for the convenience of City an equitable adjustment in the Contract price shall be made. No amount shall be allowed for anticipated profit on unperformed services, and no amount shall be paid for an as needed contract beyond the Contract termination date.

4.5.2 Termination for Default. If, after City gives notice of termination for failure to fulfill Contract obligations to Contractor, it is determined that Contractor had not so failed, the termination shall be deemed to have been effected for the convenience of City. In such event, adjustment in the Contract price shall be made as provided in Section 4.3.2. City's rights and remedies are in addition to any other rights and remedies provided by law or under this Contract.

4.6 Remedies Cumulative. City's remedies are cumulative and are not intended to be exclusive of any other remedies or means of redress to which City may be lawfully entitled in case of any breach or threatened breach of any provision of this Contract.

ARTICLE V
ADDITIONAL CONTRACTOR OBLIGATIONS

5.1 Inspection and Acceptance. The City will inspect and accept goods provided under this Contract at the shipment destination unless specified otherwise. Inspection will be made and acceptance will be determined by the City department shown in the shipping address of the Purchase Order or other duly authorized representative of City.

5.2 Responsibility for Lost or Damaged Shipments. Contractor bears the risk of loss or damage to goods prior to the time of their receipt and acceptance by City. City has no obligation to accept damaged shipments and reserves the right to return damaged goods, at Contractor's sole expense, even if the damage was not apparent or discovered until after receipt.

5.3 Responsibility for Damages. Contractor is responsible for all damage that occurs as a result of Contractor's fault or negligence or that of its' employees, agents, or representatives in connection with the performance of this Contract. Contractor shall immediately report any such damage to people and/or property to the Contract Administrator.

5.4 Delivery. Delivery shall be made on the delivery day specified in the Contract Documents. The City, in its sole discretion, may extend the time for delivery. The City may order, in writing, the suspension, delay or interruption of delivery of goods and/or services.

5.5 Delay. Unless otherwise specified herein, time is of the essence for each and every provision of the Contract. Contractor must immediately notify City in writing if there is, or it is anticipated that there will be, a delay in performance. The written notice must explain the cause for the delay and provide a reasonable estimate of the length of the delay. City may terminate this Contract as provided herein if City, in its sole discretion, determines the delay is material.

5.5.1 If a delay in performance is caused by any unforeseen event(s) beyond the control of the parties, City may allow Contractor to a reasonable extension of time to complete performance, but Contractor will not be entitled to damages or additional compensation. Any such extension of time must be approved in writing by City. The following conditions may constitute such a delay: war; changes in law or government regulation; labor disputes; strikes; fires, floods, adverse weather or other similar condition of the elements necessitating cessation of the performance; inability to obtain materials, equipment or labor; or other specific reasons agreed to between City and Contractor. This provision does not apply to a delay caused by Contractor's acts or omissions. Contractor is not entitled to an extension of time to perform if a delay is caused by Contractor's inability to obtain materials, equipment, or labor unless City has received, in a timely manner, documentary proof satisfactory to City of Contractor's inability to obtain materials, equipment, or labor, in which case City's approval must be in writing.

5.6 Restrictions and Regulations Requiring Contract Modification. Contractor shall immediately notify City in writing of any regulations or restrictions that may or will require Contractor to alter the material, quality, workmanship, or performance of the goods and/or services to be provided. City reserves the right to accept any such alteration, including any resulting reasonable price adjustments, or to cancel the Contract at no expense to the City.

5.7 Warranties. All goods and/or services provided under the Contract must be warranted by Contractor or manufacturer for at least twelve (12) months after acceptance by City, except automotive equipment. Automotive equipment must be warranted for a minimum of 12,000 miles or 12 months, whichever occurs first, unless otherwise stated in the Contract. Contractor is responsible to City for all warranty service, parts, and labor. Contractor is required to ensure that warranty work is performed at a facility acceptable to City and that services, parts, and labor are available and provided to meet City's schedules and deadlines. Contractor may establish a warranty service contract with an agency satisfactory to City instead of performing the warranty service itself. If Contractor is not an authorized service center and causes any damage to equipment being serviced, which results in the existing warranty being voided, Contractor will be liable for all costs of repairs to the equipment, or the costs of replacing the equipment with new equipment that meets City's operational needs.

5.8 Industry Standards. Contractor shall provide goods and/or services acceptable to City in strict conformance with the Contract. Contractor shall also provide goods and/or services in accordance with the standards customarily adhered to by an experienced and competent provider of the goods and/or services called for under this Contract using the degree of care and skill ordinarily exercised by reputable providers of such goods and/or services. Where approval by City, the Mayor, or other representative of City is required, it is understood to be general approval only and does not relieve Contractor of responsibility for complying with all applicable laws, codes, policies, regulations, and good business practices.

5.9 Records Retention and Examination. Contractor shall retain, protect, and maintain in an accessible location all records and documents, including paper, electronic, and computer records, relating to this Contract for five (5) years after receipt of final payment by City under this Contract. Contractor shall make all such records and documents available for inspection, copying, or other reproduction, and auditing by authorized representatives of City, including the Purchasing Agent or designee. Contractor shall make available all requested data and records at reasonable locations within City or County of San Diego at any time during normal business hours, and as often as City deems necessary. If records are not made available within the City or County of San Diego, Contractor shall pay City's travel costs to the location where the records are maintained and shall pay for all related travel expenses. Failure to make requested records available for inspection, copying, or other reproduction, or auditing by the date requested may result in termination of the Contract. Contractor must include this provision in all subcontracts made in connection with this Contract.

5.9.1 Contractor shall maintain records of all subcontracts entered into with all firms, all project invoices received from Subcontractors and Suppliers, all purchases of materials and services from Suppliers, and all joint venture participation. Records shall show name, telephone number including area code, and business address of each Subcontractor and Supplier, and joint venture partner, and the total amount actually paid to each firm. Project relevant records, regardless of tier, may be periodically reviewed by the City.

5.10 Quality Assurance Meetings. Upon City's request, Contractor shall schedule one or more quality assurance meetings with City's Contract Administrator to discuss Contractor's performance. If requested, Contractor shall schedule the first quality assurance meeting no later than eight (8) weeks from the date of commencement of work under the Contract. At the quality assurance meeting(s), City's Contract Administrator will provide Contractor with feedback, will note any deficiencies in Contract performance, and provide Contractor with an opportunity to address and correct such deficiencies. The total number of quality assurance meetings that may be required by City will depend upon Contractor's performance.

5.11 Duty to Cooperate with Auditor. The City Auditor may, in his sole discretion, at no cost to the City, and for purposes of performing his responsibilities under Charter section 39.2, review Contractor's records to confirm contract compliance. Contractor shall make reasonable efforts to cooperate with Auditor's requests.

5.12 Safety Data Sheets. If specified by City in the solicitation or otherwise required by this Contract, Contractor must send with each shipment one (1) copy of the Safety Data Sheet (SDS) for each item shipped. Failure to comply with this procedure will be cause for immediate termination of the Contract for violation of safety procedures.

5.13 Project Personnel. Except as formally approved by the City, the key personnel identified in Contractor's bid or proposal shall be the individuals who will actually complete the work. Changes in staffing must be reported in writing and approved by the City.

5.13.1 Criminal Background Certification. Contractor certifies that all employees working on this Contract have had a criminal background check and that said employees are clear of any sexual and drug related convictions. Contractor further certifies that all employees hired by Contractor or a subcontractor shall be free from any felony convictions.

5.13.2 Photo Identification Badge. Contractor shall provide a company photo identification badge to any individual assigned by Contractor or subcontractor to perform services or deliver goods on City premises. Such badge must be worn at all times while on City premises. City reserves the right to require Contractor to pay fingerprinting fees for personnel assigned to work in sensitive areas. All employees shall turn in their photo identification badges to Contractor upon completion of services and prior to final payment of invoice.

5.14 Standards of Conduct. Contractor is responsible for maintaining standards of employee competence, conduct, courtesy, appearance, honesty, and integrity satisfactory to the City.

5.14.1 Supervision. Contractor shall provide adequate and competent supervision at all times during the Contract term. Contractor shall be readily available to meet with the City. Contractor shall provide the telephone numbers where its representative(s) can be reached.

5.14.2 City Premises. Contractor's employees and agents shall comply with all City rules and regulations while on City premises.

5.14.3 Removal of Employees. City may request Contractor immediately remove from assignment to the City any employee found unfit to perform duties at the City. Contractor shall comply with all such requests.

5.15 Licenses and Permits. Contractor shall, without additional expense to the City, be responsible for obtaining any necessary licenses, permits, certifications, accreditations, fees and approvals for complying with any federal, state, county, municipal, and other laws, codes, and regulations applicable to Contract performance. This includes, but is not limited to, any laws or regulations requiring the use of licensed contractors to perform parts of the work.

5.16 Contractor and Subcontractor Registration Requirements. Prior to the award of the Contract or Task Order, Contractor and Contractor's subcontractors and suppliers must register with the City's web-based vendor registration and bid management system. The City may not award the Contract until registration of all subcontractors and suppliers is complete. In the event this requirement is not met within the time frame specified by the City, the City reserves the right to rescind the Contract award and to make the award to the next responsive and responsible proposer of bidder.

ARTICLE VI
INTELLECTUAL PROPERTY RIGHTS

6.1 Rights in Data. If, in connection with the services performed under this Contract, Contractor or its employees, agents, or subcontractors, create artwork, audio recordings, blueprints, designs, diagrams, documentation, photographs, plans, reports, software, source code, specifications, surveys, system designs, video recordings, or any other original works of authorship, whether written or readable by machine (Deliverable Materials), all rights of Contractor or its subcontractors in the Deliverable Materials, including, but not limited to publication, and registration of copyrights, and trademarks in the Deliverable Materials, are the sole property of City. Contractor, including its employees, agents, and subcontractors, may not use any Deliverable Material for purposes unrelated to Contractor's work on behalf of the City without prior written consent of City. Contractor may not publish or reproduce any Deliverable Materials, for purposes unrelated to Contractor's work on behalf of the City, without the prior written consent of the City.

6. 2 Intellectual Property Rights Assignment. For no additional compensation, Contractor hereby assigns to City all of Contractor's rights, title, and interest in and to the content of the Deliverable Materials created by Contractor or its employees, agents, or subcontractors, including copyrights, in connection with the services performed under this Contract. Contractor

shall promptly execute and deliver, and shall cause its employees, agents, and subcontractors to promptly execute and deliver, upon request by the City or any of its successors or assigns at any time and without further compensation of any kind, any power of attorney, assignment, application for copyright, patent, trademark or other intellectual property right protection, or other papers or instruments which may be necessary or desirable to fully secure, perfect or otherwise protect to or for the City, its successors and assigns, all right, title and interest in and to the content of the Deliverable Materials. Contractor also shall cooperate and assist in the prosecution of any action or opposition proceeding involving such intellectual property rights and any adjudication of those rights.

6. 3 Contractor Works. Contractor Works means tangible and intangible information and material that: (a) had already been conceived, invented, created, developed or acquired by Contractor prior to the effective date of this Contract; or (b) were conceived, invented, created, or developed by Contractor after the effective date of this Contract, but only to the extent such information and material do not constitute part or all of the Deliverable Materials called for in this Contract. All Contractor Works, and all modifications or derivatives of such Contractor Works, including all intellectual property rights in or pertaining to the same, shall be owned solely and exclusively by Contractor.

6. 4 Subcontracting. In the event that Contractor utilizes a subcontractor(s) for any portion of the work that comprises the whole or part of the specified Deliverable Materials to the City, the agreement between Contractor and the subcontractor shall include a statement that identifies the Deliverable Materials as a "works for hire" as described in the United States Copyright Act of 1976, as amended, and that all intellectual property rights in the Deliverable Materials, whether arising in copyright, trademark, service mark or other forms of intellectual property rights, belong to and shall vest solely with the City. Further, the agreement between Contractor and its subcontractor shall require that the subcontractor, if necessary, shall grant, transfer, sell and assign, free of charge, exclusively to City, all titles, rights and interests in and to the Deliverable Materials, including all copyrights, trademarks and other intellectual property rights. City shall have the right to review any such agreement for compliance with this provision.

6. 5 Intellectual Property Warranty and Indemnification. Contractor represents and warrants that any materials or deliverables, including all Deliverable Materials, provided under this Contract are either original, or not encumbered, and do not infringe upon the copyright, trademark, patent or other intellectual property rights of any third party, or are in the public domain. If Deliverable Materials provided hereunder become the subject of a claim, suit or allegation of copyright, trademark or patent infringement, City shall have the right, in its sole discretion, to require Contractor to produce, at Contractor's own expense, new non-infringing materials, deliverables or works as a means of remedying any claim of infringement in addition to any other remedy available to the City under law or equity. Contractor further agrees to indemnify, defend, and hold harmless the City, its officers, employees and agents from and against any and all claims, actions, costs, judgments or damages, of any type, alleging or threatening that any Deliverable Materials, supplies, equipment, services or works provided under this contract infringe the copyright, trademark, patent or other intellectual property or proprietary rights of any third party (Third Party Claim of Infringement). If a Third Party Claim

of Infringement is threatened or made before Contractor receives payment under this Contract, City shall be entitled, upon written notice to Contractor, to withhold some or all of such payment.

6.6 Software Licensing. Contractor represents and warrants that the software, if any, as delivered to City, does not contain any program code, virus, worm, trap door, back door, time or clock that would erase data or programming or otherwise cause the software to become inoperable, inaccessible, or incapable of being used in accordance with its user manuals, either automatically, upon the occurrence of licensor-selected conditions or manually on command. Contractor further represents and warrants that all third party software, delivered to City or used by Contractor in the performance of the Contract, is fully licensed by the appropriate licensor.

6.7 Publication. Contractor may not publish or reproduce any Deliverable Materials, for purposes unrelated to Contractor's work on behalf of the City without prior written consent from the City.

6.8 Royalties, Licenses, and Patents. Unless otherwise specified, Contractor shall pay all royalties, license, and patent fees associated with the goods that are the subject of this solicitation. Contractor warrants that the goods, materials, supplies, and equipment to be supplied do not infringe upon any patent, trademark, or copyright, and further agrees to defend any and all suits, actions and claims for infringement that are brought against the City, and to defend, indemnify and hold harmless the City, its elected officials, officers, and employees from all liability, loss and damages, whether general, exemplary or punitive, suffered as a result of any actual or claimed infringement asserted against the City, Contractor, or those furnishing goods, materials, supplies, or equipment to Contractor under the Contract.

ARTICLE VII
INDEMNIFICATION AND INSURANCE

7.1 Indemnification. To the fullest extent permitted by law, Contractor shall defend (with legal counsel reasonably acceptable to City), indemnify, protect, and hold harmless City and its elected officials, officers, employees, agents, and representatives (Indemnified Parties) from and against any and all claims, losses, costs, damages, injuries (including, without limitation, injury to or death of an employee of Contractor or its subcontractors), expense, and liability of every kind, nature and description (including, without limitation, incidental and consequential damages, court costs, and litigation expenses and fees of expert consultants or expert witnesses incurred in connection therewith and costs of investigation) that arise out of, pertain to, or relate to, directly or indirectly, in whole or in part, any goods provided or performance of services under this Contract by Contractor, any subcontractor, anyone directly or indirectly employed by either of them, or anyone that either of them control. Contractor's duty to defend, indemnify, protect and hold harmless shall not include any claims or liabilities arising from the sole negligence or willful misconduct of the Indemnified Parties.

7.2 Insurance. Contractor shall procure and maintain for the duration of the contract insurance against claims for injuries to persons or damages to property which may arise from or

in connection with the performance of the work hereunder and the results of that work by Contractor, his agents, representatives, employees or subcontractors.

Contractor shall provide, at a minimum, the following:

7.2.1 Commercial General Liability. Insurance Services Office Form CG 00 01 covering CGL on an "occurrence" basis, including products and completed operations, property damage, bodily injury, and personal and advertising injury with limits no less than $1,000,000 per occurrence. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this project/location (ISO CG 25 03 or 25 04) or the general aggregate limit shall be twice the required occurrence limit.

7.2.2 Commercial Automobile Liability. Insurance Services Office Form Number CA 0001 covering Code 1 (any auto) or, if Contractor has no owned autos, Code 8 (hired) and 9 (non-owned), with limit no less than $1,000,000 per accident for bodily injury and property damage.

7.2.3 Workers' Compensation. Insurance as required by the State of California, with Statutory Limits, and Employer's Liability Insurance with limit of no less than $1,000,000 per accident for bodily injury or disease.

7.2.4 Professional Liability (Errors and Omissions). For consultant contracts, insurance appropriate to Consultant's profession, with limit no less than $1,000,000 per occurrence or claim, $2,000,000 aggregate.

If Contractor maintains broader coverage and/or higher limits than the minimums shown above, City requires and shall be entitled to the broader coverage and/or the higher limits maintained by Contractor. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to City.

7.2.5 Other Insurance Provisions. The insurance policies are to contain, or be endorsed to contain, the following provisions:

7.2.5.1 Additional Insured Status. The City, its officers, officials, employees, and volunteers are to be covered as additional insureds on the CGL policy with respect to liability arising out of work or operations performed by or on behalf of Contractor including materials, parts, or equipment furnished in connection with such work or operations. General liability coverage can be provided in the form of an endorsement to Contractor's insurance (at least as broad as ISO Form CG 20 10 11 85 or if not available, through the addition of both CG 20 10, CG 20 26, CG 20 33, or CG 20 38; and CG 20 37 if a later edition is used).

7.2.5.2 Primary Coverage. For any claims related to this contract, Contractor's insurance coverage shall be primary coverage at least as broad as ISO CG 20 01 04 13 as respects the City, its officers, officials, employees, and volunteers. Any insurance or self-insurance maintained by City, its officers, officials, employees, or volunteers shall be excess of Contractor's insurance and shall not contribute with it.

7.2.5.3 Notice of Cancellation. Each insurance policy required above shall provide that coverage shall not be canceled, except with notice to City.

7.2.5.4 Waiver of Subrogation. Contractor hereby grants to City a waiver of any right to subrogation which the Workers' Compensation insurer of said Contractor may acquire against City by virtue of the payment of any loss under such insurance. Contractor agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the City has received a waiver of subrogation endorsement from the insurer.

7.2.5.5 Claims Made Policies (applicable only to professional liability). The Retroactive Date must be shown, and must be before the date of the contract or the beginning of contract work. Insurance must be maintained and evidence of insurance must be provided for at least five (5) years after completion of the contract of work. If coverage is canceled or non-renewed, and not replaced with another claims-made policy form with a Retroactive Date prior to the contract effective date, Contractor must purchase "extended reporting" coverage for a minimum of five (5) years after completion of work.

7.3 Self Insured Retentions. Self-insured retentions must be declared to and approved by City. City may require Contractor to purchase coverage with a lower retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention. The policy language shall provide, or be endorsed to provide, that the self-insured retention may be satisfied by either the named insured or City.

7.4 Acceptability of Insurers. Insurance is to be placed with insurers with a current A.M. Best's rating of no less than A-VI, unless otherwise acceptable to City.

City will accept insurance provided by non-admitted, "surplus lines" carriers only if the carrier is authorized to do business in the State of California and is included on the List of Approved Surplus Lines Insurers (LASLI list). All policies of insurance carried by non-admitted carriers are subject to all of the requirements for policies of insurance provided by admitted carriers described herein.

7.5 Verification of Coverage. Contractor shall furnish City with original certificates and amendatory endorsements or copies of the applicable policy language effecting coverage required by this clause. All certificates and endorsements are to be received and approved by City before work commences. However, failure to obtain the required documents prior to the work beginning shall not waive Contractor's obligation to provide them. City reserves the right to require complete, certified copies of all required insurance policies, including endorsements required by these specifications, at any time.

7.6 Special Risks or Circumstances. City reserves the right to modify these requirements, including limits, based on the nature of the risk, prior experience, insurer, coverage, or other special circumstances.

7.7 Additional Insurance. Contractor may obtain additional insurance not required by this Contract.

7.8 Excess Insurance. All policies providing excess coverage to City shall follow the form of the primary policy or policies including but not limited to all endorsements.

7.9 Subcontractors. Contractor shall require and verify that all subcontractors maintain insurance meeting all the requirements stated herein, and Contractor shall ensure that City is an additional insured on insurance required from subcontractors. For CGL coverage, subcontractors shall provide coverage with a format at least as broad as the CG 20 38 04 13 endorsement.

ARTICLE VIII
BONDS

8.1 Payment and Performance Bond. Prior to the execution of this Contract, City may require Contractor to post a payment and performance bond (Bond). The Bond shall guarantee Contractor's faithful performance of this Contract and assure payment to contractors, subcontractors, and to persons furnishing goods and/or services under this Contract.

8.1.1 Bond Amount. The Bond shall be in a sum equal to twenty-five percent (25%) of the Contract amount, unless otherwise stated in the Specifications. City may file a claim against the Bond if Contractor fails or refuses to fulfill the terms and provisions of the Contract.

8.1.2 Bond Term. The Bond shall remain in full force and effect at least until complete performance of this Contract and payment of all claims for materials and labor, at which time it will convert to a ten percent (10%) warranty bond, which shall remain in place until the end of the warranty periods set forth in this Contract. The Bond shall be renewed annually, at least sixty (60) days in advance of its expiration, and Contractor shall provide timely proof of annual renewal to City.

8.1.3 Bond Surety. The Bond must be furnished by a company authorized by the State of California Department of Insurance to transact surety business in the State of California and which has a current A.M. Best rating of at least "A-, VIII."

8.1.4 Non-Renewal or Cancellation. The Bond must provide that City and Contractor shall be provided with sixty (60) days' advance written notice in the event of non-renewal, cancellation, or material change to its terms. In the event of non-renewal, cancellation, or material change to the Bond terms, Contractor shall provide City with evidence of the new source of surety within twenty-one (21) calendar days after the date of the notice of non-renewal, cancellation, or material change. Failure to maintain the Bond, as required herein, in full force

and effect as required under this Contact, will be a material breach of the Contract subject to termination of the Contract.

8.2 Alternate Security. City may, at its sole discretion, accept alternate security in the form of an endorsed certificate of deposit, a money order, a certified check drawn on a solvent bank, or other security acceptable to the Purchasing Agent in an amount equal to the required Bond.

ARTICLE IX
CITY-MANDATED CLAUSES AND REQUIREMENTS

9.1 Contractor Certification of Compliance. By signing this Contract, Contractor certifies that Contractor is aware of, and will comply with, these City-mandated clauses throughout the duration of the Contract.

9.1.1 Drug-Free Workplace Certification. Contractor shall comply with City's Drug-Free Workplace requirements set forth in Council Policy 100-17, which is incorporated into the Contract by this reference.

9.1.2 Contractor Certification for Americans with Disabilities Act (ADA) and State Access Laws and Regulations: Contractor shall comply with all accessibility requirements under the ADA and under Title 24 of the California Code of Regulations (Title 24). When a conflict exists between the ADA and Title 24, Contractor shall comply with the most restrictive requirement (i.e., that which provides the most access). Contractor also shall comply with the City's ADA Compliance/City Contractors requirements as set forth in Council Policy 100-04, which is incorporated into this Contract by reference. Contractor warrants and certifies compliance with all federal and state access laws and regulations and further certifies that any subcontract agreement for this contract contains language which indicates the subcontractor's agreement to abide by the provisions of the City's Council Policy and any applicable access laws and regulations.

9.1.3 Non-Discrimination Requirements.

9.1.3.1 Compliance with City's Equal Opportunity Contracting Program (EOCP). Contractor shall comply with City's EOCP Requirements. Contractor shall not discriminate against any employee or applicant for employment on any basis prohibited by law. Contractor shall provide equal opportunity in all employment practices. Prime Contractors shall ensure that their subcontractors comply with this program. Nothing in this Section shall be interpreted to hold a Prime Contractor liable for any discriminatory practice of its subcontractors.

9.1.3.2 Non-Discrimination Ordinance. Contractor shall not discriminate on the basis of race, gender, gender expression, gender identity, religion, national origin, ethnicity, sexual orientation, age, or disability in the solicitation, selection, hiring or treatment of subcontractors, vendors or suppliers. Contractor shall provide equal opportunity for subcontractors to participate in subcontracting opportunities. Contractor understands and agrees that violation of this clause shall be considered a material breach of the Contract and may result

in Contract termination, debarment, or other sanctions. Contractor shall ensure that this language is included in contracts between Contractor and any subcontractors, vendors and suppliers.

9.1.3.3 Compliance Investigations. Upon City's request, Contractor agrees to provide to City, within sixty calendar days, a truthful and complete list of the names of all subcontractors, vendors, and suppliers that Contractor has used in the past five years on any of its contracts that were undertaken within San Diego County, including the total dollar amount paid by Contractor for each subcontract or supply contract. Contractor further agrees to fully cooperate in any investigation conducted by City pursuant to City's Nondiscrimination in Contracting Ordinance. Contractor understands and agrees that violation of this clause shall be considered a material breach of the Contract and may result in Contract termination, debarment, and other sanctions.

9.1.4 Equal Benefits Ordinance Certification. Unless an exception applies, Contractor shall comply with the Equal Benefits Ordinance (EBO) codified in the San Diego Municipal Code (SDMC). Failure to maintain equal benefits is a material breach of the Contract.

9.1.5 Contractor Standards. Contractor shall comply with Contractor Standards provisions codified in the SDMC. Contractor understands and agrees that violation of Contractor Standards may be considered a material breach of the Contract and may result in Contract termination, debarment, and other sanctions.

9.1.6 Noise Abatement. Contractor shall operate, conduct, or construct without violating the City's Noise Abatement Ordinance codified in the SDMC.

9.1.7 Storm Water Pollution Prevention Program. Contractor shall comply with the City's Storm Water Management and Discharge Control provisions codified in Division 3 of Chapter 4 of the SDMC, as may be amended, and any and all applicable Best Management Practice guidelines and pollution elimination requirements in performing or delivering services at City owned, leased, or managed property, or in performance of services and activities on behalf of City regardless of location.

Contractor shall comply with the City's Jurisdictional Urban Runoff Management Plan encompassing Citywide programs and activities designed to prevent and reduce storm water pollution within City boundaries as adopted by the City Council on January 22, 2008, via Resolution No. 303351, as may be amended.

Contractor shall comply with each City facility or work site's Storm Water Pollution Prevention Plan, as applicable, and institute all controls needed while completing the services to minimize any negative impact to the storm water collection system and environment.

9.1.8 Service Worker Retention Ordinance. If applicable, Contractor shall comply with the Service Worker Retention Ordinance (SWRO) codified in the SDMC.

9.1.9 Product Endorsement. Contractor shall comply with Council Policy 000-41 which requires that other than listing the City as a client and other limited endorsements, any advertisements, social media, promotions or other marketing referring to the City as a user of a product or service will require prior written approval of the Mayor or designee. Use of the City Seal or City logos is prohibited.

9.1.10 Business Tax Certificate. Unless the City Treasurer determines in writing that a contractor is exempt from the payment of business tax, any contractor doing business with the City of San Diego is required to obtain a Business Tax Certificate (BTC) and to provide a copy of its BTC to the City before a Contract is executed.

9.1.11 Equal Pay Ordinance. Unless an exception applies, Contractor shall comply with the Equal Pay Ordinance codified in San Diego Municipal Code sections 22.4801 through 22.4809. Contractor shall certify in writing that it will comply with the requirements of the EPO.

9.1.11.1 Contractor and Subcontract Requirement. The Equal Pay Ordinance applies to any subcontractor who performs work on behalf of a Contractor to the same extent as it would apply to that Contractor. Any Contractor subject to the Equal Pay Ordinance shall require all of its subcontractors to certify compliance with the Equal Pay Ordinance in its written subcontracts.

ARTICLE X
CONFLICT OF INTEREST AND VIOLATIONS OF LAW

10.1 Conflict of Interest Laws. Contractor is subject to all federal, state and local conflict of interest laws, regulations, and policies applicable to public contracts and procurement practices including, but not limited to, California Government Code sections 1090, *et. seq.* and 81000*, et. seq.,* and the Ethics Ordinance, codified in the SDMC. City may determine that Contractor must complete one or more statements of economic interest disclosing relevant financial interests. Upon City's request, Contractor shall submit the necessary documents to City.

10.2 Contractor's Responsibility for Employees and Agents. Contractor is required to establish and make known to its employees and agents appropriate safeguards to prohibit employees from using their positions for a purpose that is, or that gives the appearance of being, motivated by the desire for private gain for themselves or others, particularly those with whom they have family, business or other relationships.

10.3 Contractor's Financial or Organizational Interests. In connection with any task, Contractor shall not recommend or specify any product, supplier, or contractor with whom Contractor has a direct or indirect financial or organizational interest or relationship that would violate conflict of interest laws, regulations, or policies.

10.4 Certification of Non-Collusion. Contractor certifies that: (1) Contractor's bid or proposal was not made in the interest of or on behalf of any person, firm, or corporation not identified; (2) Contractor did not directly or indirectly induce or solicit any other bidder or proposer to put in a sham bid or proposal; (3) Contractor did not directly or indirectly induce or

solicit any other person, firm or corporation to refrain from bidding; and (4) Contractor did not seek by collusion to secure any advantage over the other bidders or proposers.

10.5 Hiring City Employees. This Contract shall be unilaterally and immediately terminated by City if Contractor employs an individual who within the twelve (12) months immediately preceding such employment did in his/her capacity as a City officer or employee participate in negotiations with or otherwise have an influence on the selection of Contractor.

ARTICLE XI
DISPUTE RESOLUTION

11.1 Mediation. If a dispute arises out of or relates to this Contract and cannot be settled through normal contract negotiations, Contractor and City shall use mandatory non-binding mediation before having recourse in a court of law.

11.2 Selection of Mediator. A single mediator that is acceptable to both parties shall be used to mediate the dispute. The mediator will be knowledgeable in the subject matter of this Contract, if possible.

11.3 Expenses. The expenses of witnesses for either side shall be paid by the party producing such witnesses. All other expenses of the mediation, including required traveling and other expenses of the mediator, and the cost of any proofs or expert advice produced at the direct request of the mediator, shall be borne equally by the parties, unless they agree otherwise.

11.4 Conduct of Mediation Sessions. Mediation hearings will be conducted in an informal manner and discovery will not be allowed. The discussions, statements, writings and admissions will be confidential to the proceedings (pursuant to California Evidence Code sections 1115 through 1128) and will not be used for any other purpose unless otherwise agreed by the parties in writing. The parties may agree to exchange any information they deem necessary. Both parties shall have a representative attend the mediation who is authorized to settle the dispute, though City's recommendation of settlement may be subject to the approval of the Mayor and City Council. Either party may have attorneys, witnesses or experts present.

11.5 Mediation Results. Any agreements resulting from mediation shall be memorialized in writing. The results of the mediation shall not be final or binding unless otherwise agreed to in writing by the parties. Mediators shall not be subject to any subpoena or liability, and their actions shall not be subject to discovery.

ARTICLE XII
MANDATORY ASSISTANCE

12.1 Mandatory Assistance. If a third party dispute or litigation, or both, arises out of, or relates in any way to the services provided to the City under a Contract, Contractor , its agents, officers, and employees agree to assist in resolving the dispute or litigation upon City’s request. Contractor’s assistance includes, but is not limited to, providing professional consultations,

attending mediations, arbitrations, depositions, trials or any event related to the dispute resolution and/or litigation.

12.2 Compensation for Mandatory Assistance. City will compensate Contractor for fees incurred for providing Mandatory Assistance. If, however, the fees incurred for the Mandatory Assistance are determined, through resolution of the third party dispute or litigation, or both, to be attributable in whole, or in part, to the acts or omissions of Contractor, its agents, officers, and employees, Contractor shall reimburse City for all fees paid to Contractor, its agents, officers, and employees for Mandatory Assistance.

12.3 Attorneys' Fees Related to Mandatory Assistance. In providing City with dispute or litigation assistance, Contractor or its agents, officers, and employees may incur expenses and/or costs. Contractor agrees that any attorney fees it may incur as a result of assistance provided under Section 12.2 are not reimbursable.

ARTICLE XIII
MISCELLANEOUS

13.1 Headings. All headings are for convenience only and shall not affect the interpretation of this Contract.

13.2 Non-Assignment. Contractor may not assign the obligations under this Contract, whether by express assignment or by sale of the company, nor any monies due or to become due under this Contract, without City's prior written approval. Any assignment in violation of this paragraph shall constitute a default and is grounds for termination of this Contract at the City's sole discretion. In no event shall any putative assignment create a contractual relationship between City and any putative assignee.

13.3 Independent Contractors. Contractor and any subcontractors employed by Contractor are independent contractors and not agents of City. Any provisions of this Contract that may appear to give City any right to direct Contractor concerning the details of performing or providing the goods and/or services, or to exercise any control over performance of the Contract, shall mean only that Contractor shall follow the direction of City concerning the end results of the performance.

13.4 Subcontractors. All persons assigned to perform any work related to this Contract, including any subcontractors, are deemed to be employees of Contractor, and Contractor shall be directly responsible for their work.

13.5 Covenants and Conditions. All provisions of this Contract expressed as either covenants or conditions on the part of City or Contractor shall be deemed to be both covenants and conditions.

13.6 Compliance with Controlling Law. Contractor shall comply with all applicable local, state, and federal laws, regulations, and policies. Contractor's act or omission in violation of applicable local, state, and federal laws, regulations, and policies is grounds for contract

termination. In addition to all other remedies or damages allowed by law, Contractor is liable to City for all damages, including costs for substitute performance, sustained as a result of the violation. In addition, Contractor may be subject to suspension, debarment, or both.

13.7 Governing Law. The Contract shall be deemed to be made under, construed in accordance with, and governed by the laws of the State of California without regard to the conflicts or choice of law provisions thereof.

13.8 Venue. The venue for any suit concerning solicitations or the Contract, the interpretation of application of any of its terms and conditions, or any related disputes shall be in the County of San Diego, State of California.

13.9 Successors in Interest. This Contract and all rights and obligations created by this Contract shall be in force and effect whether or not any parties to the Contract have been succeeded by another entity, and all rights and obligations created by this Contract shall be vested and binding on any party's successor in interest.

13.10 No Waiver. No failure of either City or Contractor to insist upon the strict performance by the other of any covenant, term or condition of this Contract, nor any failure to exercise any right or remedy consequent upon a breach of any covenant, term, or condition of this Contract, shall constitute a waiver of any such breach of such covenant, term or condition. No waiver of any breach shall affect or alter this Contract, and each and every covenant, condition, and term hereof shall continue in full force and effect without respect to any existing or subsequent breach.

13.11 Severability. The unenforceability, invalidity, or illegality of any provision of this Contract shall not render any other provision of this Contract unenforceable, invalid, or illegal.

13.12 Drafting Ambiguities. The parties acknowledge that they have the right to be advised by legal counsel with respect to the negotiations, terms and conditions of this Contract, and the decision of whether to seek advice of legal counsel with respect to this Contract is the sole responsibility of each party. This Contract shall not be construed in favor of or against either party by reason of the extent to which each party participated in the drafting of the Contract.

13.13 Amendments. Neither this Contract nor any provision hereof may be changed, modified, amended or waived except by a written agreement executed by duly authorized representatives of City and Contractor. Any alleged oral amendments have no force or effect. The Purchasing Agent must sign all Contract amendments.

13.14 Conflicts Between Terms. If this Contract conflicts with an applicable local, state, or federal law, regulation, or court order, applicable local, state, or federal law, regulation, or court order shall control. Varying degrees of stringency among the main body of this Contract, the exhibits or attachments, and laws, regulations, or orders are not deemed conflicts, and the most stringent requirement shall control. Each party shall notify the other immediately upon the identification of any apparent conflict or inconsistency concerning this Contract.

13.15 Survival of Obligations. All representations, indemnifications, warranties, and guarantees made in, required by, or given in accordance with this Contract, as well as all continuing obligations indicated in this Contract, shall survive, completion and acceptance of performance and termination, expiration or completion of the Contract.

13.16 Confidentiality of Services. All services performed by Contractor, and any sub-contractor(s) if applicable, including but not limited to all drafts, data, information, correspondence, proposals, reports of any nature, estimates compiled or composed by Contractor, are for the sole use of City, its agents, and employees. Neither the documents nor their contents shall be released by Contractor or any subcontractor to any third party without the prior written consent of City. This provision does not apply to information that: (1) was publicly known, or otherwise known to Contractor, at the time it was disclosed to Contractor by City; (2) subsequently becomes publicly known through no act or omission of Contractor; or (3) otherwise becomes known to Contractor other than through disclosure by City.

13.17 Insolvency. If Contractor enters into proceedings relating to bankruptcy, whether voluntary or involuntary, Contractor agrees to furnish, by certified mail or electronic commerce method authorized by the Contract, written notification of the bankruptcy to the Purchasing Agent and the Contract Administrator responsible for administering the Contract. This notification shall be furnished within five (5) days of the initiation of the proceedings relating to bankruptcy filing. This notification shall include the date on which the bankruptcy petition was filed, the identity of the court in which the bankruptcy petition was filed, and a listing of City contract numbers and contracting offices for all City contracts against which final payment has not been made. This obligation remains in effect until final payment is made under this Contract.

13.18 No Third Party Beneficiaries. Except as may be specifically set forth in this Contract, none of the provisions of this Contract are intended to benefit any third party not specifically referenced herein. No party other than City and Contractor shall have the right to enforce any of the provisions of this Contract.

13.19 Actions of City in its Governmental Capacity. Nothing in this Contract shall be interpreted as limiting the rights and obligations of City in its governmental or regulatory capacity.

EXHIBIT E

COBRA Administration Services

HQY provides COBRA administration services through HQY's Affiliate, WageWorks, Inc. ("**WW**"). This Schedule sets forth the COBRA administration services to be provided by WW to Employer and are incorporated into the Agreement. Capitalized terms used in this Schedule, but not defined herein, shall have the meanings ascribed to them in the Terms and Conditions to the Agreement. Notwithstanding anything in this Schedule to the contrary, HQY (or any of its other Affiliates) may provide COBRA Services in place of WW.

Employer has independently concluded that one or more of its group health plans are subject to the provisions of COBRA.

1 Definitions. For purposes of this Schedule, the following definitions are included in addition to those in the Agreement:

1.1 "Administrative User" means an employee of Employer who is authorized to access and use the COBRA Portal to administer COBRA benefits established by or on behalf of Employer.

1.2 "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and its associated regulations.

1.3 "COBRA Continuant" is a Qualified Beneficiary, or other individual, who has elected COBRA continuation coverage.

1.4 "COBRA Portal" means the WW web-based software applications to which Employer and/or Qualified Beneficiaries are granted access.

1.5 "Covered Employee" means an employee of Employer who is eligible for group coverage under an Employer group health plan.

1.6 "Party" or "Parties" shall have the meaning given to it in the Agreement but shall also specifically include WageWorks, Inc.

1.7 "Qualified Beneficiary" means any individual specified in COBRA who is identified or confirmed by Employer as eligible to receive COBRA continuation coverage under an Employer group health plan.

1.8 "Services" means processing and administration of COBRA benefits by WW for Employer under this Schedule.

2 Relationship.

2.1 The Parties acknowledge and agree that this Schedule is solely between WW and Employer, and is independent of any relationship that either WW or Employer may have with an insurance carrier, third party administrator, benefits administrator, or any other third party. For purposes of this Schedule, the term "Employer" shall mean Employer in its capacity as plan sponsor of one or more group health plans or employee welfare benefit plans.

2.2 The Parties also acknowledge and agree that WW shall have no responsibility for the funding of COBRA premium payments, or the payment of any claims under any of the Employer's group health plans and WW's hereunder are solely those duties specifically undertaken in this Schedule. WW's obligations hereunder are subject to, and contingent upon, Employer's accurate and timely compliance with the duties set forth in Section 4. In all events, Employer is responsible for compliance with COBRA, state-specific continuation laws and all other applicable law, including with respect to all notices, communications, and other documents prepared and distributed by WW, and WW's COBRA administration and state-specific continuation administration processes.

3 WW Duties.

Program setup	a. Conduct a welcome and implementation phone call with Employer to complete a program election questionnaire that includes Employer's COBRA program elections and desired COBRA Portal configurations. b. After all necessary information is received by WW, WW shall complete all required COBRA Portal configuration to match Employer's elections, provided, however, that WW will identify all elections that it cannot configure and work with Employer to resolve the configuration. c. Provide Administrative Users with training on how to use the COBRA Portal.
Employer file integration	d. Educate Administrative User on available methods for Employer to submit data or files to the COBRA Portal, e.g., qualifying event files, Covered Employee files, etc. Available options are: (i) manual entry on the COBRA Portal, (ii) upload a file in an approved format (.csv, .txt, or .xlsx), and (iii) have a third-party benefits administrator send WW a file in an approved format (.csv, .txt, or .xlsx).
Takeover of existing COBRA Continuants	e. Support transition from prior administrator of existing COBRA Continuants who have elected COBRA continuation coverage. f. Send a welcome letter to COBRA Continuants explaining the transition of services to WW, and payment coupons or invoices to COBRA Continuants.
Open Enrollment ("OE")	Open Enrollment Services, generally. During implementation, Employer will be set up with the Partial Open Enrollment service, unless Employer otherwise elects the 'standard' or 'custom' options. If Employer elects the 'standard' or 'custom Open Enrollment service, Employer shall provide written notification to WW of its choice. g. Partial: i. Partial service applies to Employers that mail their own OE materials and process their own OE elections. ii. Employer must advise WW of any required updates utilizing a mutually agreed method (i.e., WW's standard format or an existing format WW already receives). iii. WW will manage adding, updating or terminating plans; carrier and billing updates; and will produce and mail a rate change notice with the updated rates to Qualified Beneficiaries and COBRA Continuants (which, for clarity, includes pending COBRA Continuants) providing the applicable COBRA premium change for the Employer's plan(s)' next determination period. iv. Postage and additional printing fees may apply in some situations and will be disclosed to the Employer. v. For clarity, the Partial service does not include the fulfillment of the OE materials or processing of election forms. h. Standard: Standard OE shall include part (iii) of the Partial OE offering as well as the following: i. WW updates, prints, and mails OE notifications on behalf of the Employer, up to 7 sheets of paper (double-sided), to Qualified Beneficiaries and COBRA Continuants (which, for clarity, including pending COBRA Continuants). WW will provide carrier and billing updates. ii. Postage and additional printing fees may apply in some situations and will be disclosed to the Employer.

	i. Custom: Custom OE shall include part (iii) of the Partial OE offering as well as the following: i. WW updates, prints, and mails OE notifications on behalf of the Employer, up to 30 sheets of paper (double-sided), to Qualified Beneficiaries and COBRA Continuants (which, for clarity, including pending COBRA Continuants). WW will provide carrier and billing updates. ii. Special handling for division-based communications and/or custom inserts. Postage and additional printing fees may apply in some situations and will be disclosed to Employer.
Ongoing monthly administration	j. WW shall provide the following ongoing monthly administration Services, as applicable: 1. Provide a website (the COBRA Portal) through which Qualified Beneficiaries may view program communications, make benefit elections, and process COBRA premium payments; 2. Provide a website (the COBRA Portal) through which Employer may view program information, access reports, and take the following actions: • Allow Employer to manually enter qualifying events; and • View Qualified Beneficiary information, e.g., COBRA election status, communications mailed to the Qualified Beneficiary, and payment history; 3. Receive and process qualifying event files and, if elected by Employer, General-Notice-of-COBRA-Continuation-Coverage-Rights file; 4. Provide general communications to Qualified Beneficiaries, and provide required notices to Qualified Beneficiaries (subject to receipt of timely and accurate information from Employer); 5. Process COBRA elections received by mail from Qualified Beneficiaries and elections entered by Qualified Beneficiaries on the COBRA Portal, and send COBRA premium payment coupons to COBRA Continuants; 6. Process monthly COBRA premium payments received via mail or via the COBRA Portal; 7. Remit COBRA premium payments monthly to the Employer (or Employer's insurance carrier, if such additional service is elected by Employer); 8. Process COBRA terminations (process includes applicable conversion notifications if Employer's plan allows a conversion policy); 9. Work with Employer and carriers to resolve any escalated issues; 10. Notify carriers of elections, terminations and coverage changes; and Unless expressly stated otherwise in an addendum to this Schedule, WW shall not administer any plan-specific rules that WW determines deviate from the minimum requirements under COBRA.
State-Specific Services	k. If Employer requests for WW to provide state-specific continuation coverage notices, other state-specific continuation services or wishes to offer COBRA

	benefits to non-qualified beneficiary populations (i.e. domestic partners, parents), Employer will notify WW in writing and, if such state-specific services are offered by WW, a separate, additional, schedule may be provided with additional fees applicable to such schedule. Notwithstanding the foregoing, WW reserves the ability to reject requests to comply with any plan-specific or state-specific requirements if the request would not be reasonably administrable within the parameters of WW's COBRA administration system, as determined by WW in its sole discretion.
Customer service	l. WW shall make available to Qualified Beneficiaries a toll-free number (in the US) to access its COBRA service center. As an accommodation and on a case-by-case basis, and unless otherwise directed by the Employer, WW shall provide reasonable levels of assistance to Qualified Beneficiaries who have questions about or difficulties in obtaining coverage instated or reinstated by calling the applicable Plan or the applicable Plan's insurer. However, in all such cases, Employer is ultimately responsible for the instatement or reinstatement of coverage and for the terms of its Plan(s). WW reserves the right to refer Qualified Beneficiaries to Employer at any time for all questions related to coverage, including instatement or reinstatement of coverage by any insurer of any Plan(s). m. WW shall make available to Qualified Beneficiaries a toll-free fax number (in the US).
Escheatment	n. To the extent applicable, WW will return unassociatable or unused funds related to plan or program services to Employer who shall be responsible for compliance with escheatment obligations (if any). If Employer is not able to, or declines to, accept returned funds, then Employer agrees that WW will be entitled to the funds as part of its overall compensation for services. If WW is not able to locate Employer, then WW (the holder) will comply with applicable state unclaimed property laws regarding the funds, which may require WW to escheat funds in the name of Employer (the owner) to the relevant state.

4 Employer Duties.

Program setup	a. Employer to provide all necessary information that includes Employer's COBRA program elections and desired COBRA Portal configurations, including open enrollment in accordance with Section 3.
Designate contact	b. Employer shall designate at least one employee as the primary contact who has familiarity with the Employer's COBRA benefits program. The contact shall provide WW with advance notice before any changes to the Employer's COBRA benefits program become effective and shall be available to consult with WW from time to time as reasonably necessary for WW to provide the COBRA administration services described herein. For the avoidance of doubt, no change shall become effective unless and until accepted and programmed by WW.
Provide data	c. Employer shall be responsible for providing WW with accurate, complete and timely data. WW's responsibility for sending required notifications to Qualified Beneficiaries and Covered Employees (if elected) is contingent upon Employer providing WW with accurate, complete, and timely information. Employer is responsible for correcting errors in all data sent to WW.

	d. To the extent that Protected Health Information ("PHI") (as defined in the HIPAA Regulations) is transmitted by Employer to WW or the COBRA Portal, Employer shall make any such transmission in a secure and encrypted manner, and in accordance with HIPAA, and other applicable privacy rules and regulations. e. For any notice required by COBRA to be given to Covered Employees, or Qualified Beneficiaries, Employer shall provide all information required for WW to send the notices on behalf of Employer at least 7 business days prior to the date on which the notice is required to be given under COBRA. All such information must be provided to WW by manually entering the information into the COBRA Portal or by uploading an appropriate file using the required file format (.csv, .txt, or .xlsx). f. Provide plan and rate information for the new plan year at least 60 days in advance of the date on which the updates will become effective. g. WW will not be responsible for any liabilities, penalties, or losses due to data or information that is untimely, inaccurate or otherwise invalid and Employer's indemnification obligations set forth in Section 10.2 of the Agreement shall apply with respect to any Losses asserted or arising from Employer's failure to provide WW with accurate, complete and timely data.
Covered Employees	h. At least once annually, or more frequently if requested by WW, Employer will provide WW with its then current number of Covered Employees.
Employer access	i. Employer shall: (i) notify WW when an Administrative User's access is terminated (i.e. termination of employment; (ii) keep Employer and Employer's Administrative Users' passwords used to access the COBRA Portal confidential and secure; (iii) prohibit Employer and Employer Administrative Users from attempting to gain unauthorized access to the COBRA Portal and all related systems or networks; and (iv) implement prudent management controls with respect to Employer and Employer's Administrative Users' access to and use of the COBRA Portal, which include segregation of duties among multiple Administrative Users and dual approvals for key activities.

Reimbursement Arrangements (RAs)(FSAs)

This Reimbursement Arrangements (RAs) Schedule to the Agreement sets forth the services provided for HRAs, FSAs, and DCRAs (each defined below), and is incorporated into and made a part of the Agreement. Capitalized terms used in this RA Schedule, but not defined herein, shall have the meanings ascribed to them in the Terms and Conditions to the Agreement.

1 Clarification of roles, relationships, and applicable law.

1.1 Roles and Relationships. Employer, operating as the sponsor of a health plan, "plan administrator" and "fiduciary" within the meaning of the Employee Retirement Income Security Act of 1974, as amended, desires to provide certain health related reimbursement arrangements and/or other work-related benefits to its eligible employees ("Participants"). HQY provides third party administration ("TPA") services for health reimbursement arrangements as defined in IRS Notice 2002-45 ("HRAs"), health flexible spending arrangements as defined in 26 USC § 125 and the regulations thereunder ("FSAs"), dependent care assistance programs as defined in 26 USC § 129 and the regulations thereunder ("DCRA"), and limited-purpose FSAs and post-deductible HRAs (each within the meaning of Rev. Rul. 2004-45).

1.2 Directed TPA. HQY shall operate as a directed third-party administrator ("TPA") under the Agreement and this Schedule, and not as a plan administrator, plan fiduciary, or claims fiduciary. As such, Employer shall be responsible for the proper administration of the plan, the direction of HQY's activities in accordance with the plan documents, compliance with legal requirements applicable to the plan and its administration, and ensuring that the TPA services are accurately reflected in the plan documents.

1.3 HIPAA. Unless otherwise indicated, Participant data disclosed to or held by HQY under this Schedule is governed by or subject to the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act, and the regulations promulgated thereunder (together, "HIPAA"). As such, HQY shall operate as a business associate (as defined by HIPAA) to Employer or its health plan in the provision of TPA services to the plan. Participant data is considered HIPAA protected health information ("PHI") and subject to the protections set forth in the Business Associate Agreement entered between HQY and Employer, limited by applicable record retention requirements imposed by the IRS for tax advantaged accounts and arrangements.

2 HQY duties. Employer directs HQY to do the following:

Plan setup	• Provide a plan setup worksheet for Employer to choose among certain features and options, subject to availability on HQY's system. • For HRAs, provide a Summary of Benefits and Coverage (SBC) template to Employer, along with sample language. • Optional: Provide a basic plan document template to Employer, based on, among others, the features and options chosen. Such template is not customizable. Limitations • Employer is responsible for legal review and adoption of the plan in accordance to the requirements of applicable law. • HQY will not provide legal advice as to which options or features Employer may wish to implement or with respect to compliance with applicable law.
Enrollment	• HQY will instruct Employer on how to provide timely accurate and complete enrollment information (via file or portal). • Once such information is received, HQY shall send the welcome kit and debit

	card (if elected and available). The debit card may be sent under separate cover (if elected). • HQY is not responsible for sending privacy policies or notices related to reimbursement arrangements.
Recording contributions	• If DCRA is elected as a service, Employer shall provide HQY with each Participant's DCRA elections, the corresponding payroll data, and any Employer contributions, so that HQY can create a proper account balance for the DCRA. DCRA payments are not released until funds are credited to the account. • For FSAs, HQY can record payroll contributions based on the payroll frequency provided by Employer.
Individual account management / Member Services	• HQY shall host a Participant accessible website to help Participants manage their Reimbursement Account online where they can, among other activities: a. access their account balance, distribution history, and transaction activities; b. review, enter and pay claims; c. update their email preferences; and d. download account servicing (e.g., distribution request) forms. • The website shall be made available 24/7 except for routine maintenance. Participants must have a computing device that is capable of using secure HTTP (HTTPS) to use the Participants-only area of the website. • HQY shall make available to Participants a 24/7 toll-free number (in the US) to access HQY Member Services Specialists. • HQY shall make available monthly statements to Participants to view and download from the website.
Distribution and use of plan funds	• If the Employer elected, HQY shall send to Participants debit cards (debit cards optional), available with health FSAs and limited set of HRA plans) to access Reimbursement Account funds at merchants offering medical-related (including pharmacy, dental, and vision) qualified products and services. Whether the debit card can be used at any particular merchant depends on the merchant's coding under the debit card processing system. • HQY shall make available a directed payment mechanism on the website whereby Participants can direct their funds to be paid to one or more service providers. Participants are solely responsible to: a. provide complete and accurate payee and identification so that payment can be properly credited by the provider; and b. ensure sufficient funds and time for HQY to make such directed payments. • Participants may request distribution of their funds by completing a claim form, together with the documentation required by law. a. All claim forms and supporting documents must be in English, or if not in English, accompanied by an English translation. HQY does not provide translation services. b. Participants shall receive distributions via electronic means at no cost to the Participants. Participants who request paper checks may be charged a fee per check. • If applicable thresholds are met, HQY shall provide a mechanism to securely receive adjudicated claims files from Employer's health plan(s). HQY shall populate Participants accounts with the claim data so that Participants may pay the patient responsibility portion of adjudicated claims directly from the account. • If Participant's account balance is insufficient to pay all claims, debit card transactions will take priority over the competing demand for funds, followed by directed payments. • HQY will attempt to auto-substantiate card transactions using IRS approved methods. If auto-substantiation cannot be achieved, HQY will send a notice to

	Participant at 30 and 90 days after debit card use asking for documentation. • HQY does not turn off debit cards for failure to substantiate transactions, without a prior written directive from the Employer. Employer is responsible for determining how to handle collection from Participants of any amounts that the Participant has not substantiated.
Participant education	• HQY shall make information available, either directly or through the health plan, to help Participants save and spend their account balances. This may include Employer specific educational programs and e-mail based messaging (subject to HQY having accurate e-mail addresses for e-mail distribution).
Reports to Employer	• HQY shall make reports available to Employer that include a summary roll-up of account transactions, a funding ledger, and claims detail, including overpayments.
Escheatment	• HQY will return unassociatable or unused funds related to plan or program services to Employer who shall be responsible for compliance with escheatment obligations (if any). If Employer is not able to, or declines to, accept returned funds, then Employer agrees that HQY will be entitled to the funds as part of its overall compensation for services. If HQY is not able to locate Employer, then HQY (the holder) will comply with applicable state unclaimed property laws regarding the funds, which may require HQY to escheat funds in the name of Employer (the owner) to the relevant state.
Non-discrimination testing	Non-discrimination testing. If Employer elects this service, HQY will run the test through a third-party tool using the data provided by Employer. The tool provides basic recommendations for high-level plan adjustments to be made in order to keep the plan from being discriminatory. Employer considers the feedback and alters the plan accordingly. Employer is responsible plan design and compliance. HQY does not monitor plan compliance matters.

3 Employer duties.

Program setup	• Complete a plan setup worksheet for Employer to choose among certain features and options, subject to availability on HQY's system.
Designate contact	• Designate at least one employee as the primary contact who has familiarity with the Employer's benefits offering; the contact shall provide HQY with advance notice before any changes to the Employer's benefits offering become effective; the contact shall also be available to consult with HQY from time to time as reasonably necessary for HQY to provide the services described herein. For the avoidance of doubt, no change shall become effective unless and until accepted and programmed by HQY.
Prepare and distribute materials	• Ensure compliance with all requirements of ERISA, the Internal Revenue Code, and other applicable law, including maintaining plan documents and the preparation, distribution, and review of Summary Plan Description, Summary of Benefits and Coverage, and any other program materials to Participants.
Eligibility and contribution Data	• Ensure that all eligibility and contribution data files that are sent to HQY or data entries made on HQY's system are timely, accurate, complete, and free of errors. • HQY will not be responsible for any liabilities, penalties, or losses due to data or information that is untimely, inaccurate, otherwise invalid. Employer shall pay HQY for all costs due to any inaccurate, incomplete or erroneous data. For example, if Employer enrolls individuals who are not eligible to participate in a Reimbursement Account, Employer shall pay HQY for (i) time and materials to collect any disbursements already made to such individuals (if legally

	permitted); (ii) notifications to affected individuals; and (iii) debit card cancellation fees. The monthly fees for such ineligible individuals are (a) still payable if not already paid, or (b) if paid, are not refundable or creditable against future invoices.
Claim data	• Ensure that its health plan(s) provide claim files that are timely, accurate, complete, and free of errors. • If disbursements are made because Employer or its delegates have provided information that is untimely, inaccurate, incomplete, or otherwise erroneous, Employer agrees that HQY is not responsible for recovering the funds from any payee.
Payment of claims invoices	• Employer is responsible for paying claim invoices. • If Employer does not pay an invoice, then HQY may take appropriate remediation efforts, such as (i) deactivating cards or (ii) terminating services.
Funding	• Employer shall timely provide to HQY all benefit claims funding amounts (including any pre-funding needed). Employer acknowledges and agrees that all benefits claim pre-funding amounts submitted by Employer to HQY: (i) shall be comprised of Employer's general assets; (ii) does not consist of Plan assets within the meaning of ERISA, without regard to whether ERISA applies, and is not otherwise subject to any restrictions; and (iii) shall not be segregated or set aside in a trust or escrow account by HQY. Employer agrees to pay HQY the entire amount delivered, or deliverable, to participants in all Plans or programs, regardless of whether Employer collects sufficient payroll deductions from Employer's participants. • Employer shall be solely responsible to ensure proper funding under the Agreement. • If it is determined that the amount of prefunding requested from the Employer is not sufficient, HQY may request additional prefunding.
Legal compliance	• Employer is responsible for compliance of its Plan with Applicable Law, including, without limitation, the review and approval of HQY's form documents and templates, and HQY's administration process as they relate to the Services provided with respect to the Plan.

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Attachment C

COBRA and Flexible Spending Accounts (FSA) RFP Questionnaire

Active Plan Year runs from
January 1 through December 31
Proposed contract effective date:
January 1, 2025

INSTRUCTIONS

The following questions are intended to assess your capabilities and services for COBRA, Healthcare Flexible Spending Accounts (HCFSAs), and Dependent Care FSAs (DCFSAs). Please provide responses in the Vendor Response section.
• Please provide responses below in the Vendor Response sections.
• Please do not alter any questions. Also, please do not alter any fields by merging them, deleting them, or changing the structure of the document.

	Section 1 - General Information		Vendor Response
1	Provide the following details about your company:	1	**Company details:**
1a	Number of years in business	1a	22
1b	Number of years providing COBRA, HCFSA, and DCFSA, account services to employers and their employees	1b	38
1c	Headquarters location	1c	Draper, Utah
1d	Current number of employees	1d	3,157
1e	Total number of employer-based clients that you currently provide spending account administration for	1e	115,000
1f	Total number of employer-sponsored clients that have between 10,000 - 15,000 employees that you provide spending account administrative services for	1f	COBRA: 86 FSA: 125
1g	Employer-sponsored client size range by number of employees	1g	HealthEquity provides services to employer groups of all sizes. Our smallest client has fewer than 20 employees. Our largest client has more than two million employees.

1h	Provide a brief description of the company size and organizational structure	1h	In 2002 HealthEquity was established to transform the healthcare industry by empowering employers and individuals with tools to help manage healthcare costs, emphasize greater cost transparency, and realize savings opportunities. We reimagined what employee benefits could be and became an innovator in providing technology-enabled services that empower consumers to make healthcare saving and spending decisions. Today we offer total benefits solutions to 115,000 clients nationwide, with our services impacting 1/7 of the American workforce. HealthEquity is a publicly traded corporation (NASDAQ:HQY) headquartered in Draper, Utah.
1i	Please confirm that you have serviced similar City government organizations as part of your book of business in the past two years.	1i	Yes
1j	Confirm you can provide COBRA, HCFSA, and DCFSA to active employees.	1j	Yes
2	Describe any changes in the structure of your company (including addition/deletion of office locations, addition/removal of product lines or staff reductions, acquisitions/mergers and IPO) that have occurred over the past 12 months or are anticipated within the next 24 months.	2	Not applicable.
3	Please provide your most recent Net Promoter score.	3	Our most recent NPS for members was 62.3.
4	Do you have Errors and Omissions Liability coverage?	4	Yes
4a	If Yes, please provide the coverage limit.	4a	$5,000,000
5	Provide the most recent ratings and date of ratings for your company by the major rating organizations (i.e. A.M. Best, Fitch Ratings, Duff & Phelps, Dun & Bradstreet, Moody's, Standard & Poor's, TheStreet.com, and Weiss Ratings).	5	HealthEquity's most recent financial ratings are: □ Dun & Bradstreet (D&B): 80 o Cash flow risk rating 97 □ Moody's: Ba3 □ Standard Poor's (S&P Global): BB
6	Vendor confirms understanding of the contract being effective 1/1/2025	6	Yes
6a	Vendor confirms that they understand the Flexible Spending Accounts benefits are scheduled on a calendar-year basis, from January - December.	6a	Yes
7	In performance of this contract, the selected Vendor is required to comply with all applicable federal, state and local laws, ordinance, codes and regulations. The cost of permits and other relevant costs required in the performance of the contract shall be borne by the successful firm.	7	Yes, confirmed
7a	If applicable, describe any deviations here:	7a	Not applicable.
8	Describe any pending lawsuits that you are required to disclose in your upcoming annual report or state regulatory filings. Also describe any litigation or governmental or regulatory action pending against your organization that might have a bearing on your ability to provide services to the City.	8	Please see Note 7. Legal Matters contained in our Form 10-K, which can be accessed using the following link https://ir.healthequity.com/sec-filings. To our knowledge, there is no litigation or governmental or regulatory action pending against our organization that might have a bearing on our ability to provide services to the City.

9	Within the last five years, has your firm ever defaulted on a contract for providing administrative services? Has your firm been involved in litigation regarding such contracts?	9	No
9a	If Yes, provide specifics.	9a	Not applicable.
10	Are any of your proposed services outsourced or subcontracted?	10	Some of the proposed services are subcontracted or outsourced
10a	If some or all services are outsourced or subcontracted, please provide details including organization name, function, and scope of work. This may be provided as a separate attachment.	10a	While HealthEquity provides core benefit administration services internally, we partner with expert partners to support key services. Key service partners for FSA include: □ Total Systems (TSYS): Partner since 2009 providing welcome kits, tax forms, and supporting small print jobs. □ Fiserv: Partner since 2006 providing debit card production and transaction processing, fulfillment vendor for Quick Start Guides, explanations of benefits, and check/direct deposit. □ VPay®: Partner since 2014 providing payment processing to providers. □ RTO Technologies: Partner since 2015 providing plan document generation software and nondiscrimination testing. □ Conduent: Partner since 1995 providing call center, chat and claims processing services. □ DataBank: Partner since 2013 providing platform hosting services. □ RackSpace: Partner since 2007 providing hosting services for the platform (back up data center) For COBRA, we utilize the following service partners: □ Conduent - Call Center services □ RackSpace - Hosting services for the platform
10b	If some or all services are outsourced or subcontracted, how do you ensure that PHI and sensitive financial data is being protected?	10b	We partner with a limited number of service providers that assist in administrative processes in areas such as claims processing, data center hosting, and call center support. Other than these partner service providers, we do not share customer information with other organizations. Employment in all functional areas (including subcontractors) is contingent upon a successful pre-employment screening. Pre-employment screening includes criminal and credit checks, education, employment, and reference verification.
10c	If some or all services are outsourced or subcontracted, please confirm that your organization has fully vetted the vendor and accepts responsibility in event of breach	10c	Yes, agreed to
11	Vendor confirms that they are FDIC insured.	11	HealthEquity maintains a diverse mix of depository partners. We partner with proven FDIC-insured partners and monitor stability ongoing.
12	For COBRA, HCFSA, and DCFSA account administration, do you own your own platform or do you utilize third-party software?	12	Own (proprietary)
12a	If Other was selected, please provide details.	12a	Not applicable.
	Section 2 - FSA General Information		
13	Do you have an employer and participant (member) portal?	13	Yes
13a	Will the employer portal provide the City with the ability to make updates in real time to correct enrollment errors?	13a	Yes
13b	Will the employer portal provide the City with the ability to make updates in real time to account funding?	13b	Yes

13c	Will the employer portal provide the City with the ability to perform on-demand reporting in real time?	13c	Yes
13d	Are there any major changes planned in the future, such as, but not limited to, software changes?	13d	Yes
13e	If No was selected in response to Questions 13a, 13b, 13c, and/or 13d, please explain.	13e	HealthEquity's roadmap reflects our commitment as a strategic and innovative partner—relentlessly focused on holistic consumer-driven benefits that create better health and financial outcomes for employees. It was created in partnership with our clients and members, based on HealthEquity employer and member research, as well as market trends. Over the next two to three years, our roadmap is focused on a member-first experience, integrated technology, and more personalized education. Anticipated roadmap initiatives include: **Journey to Digital Card** •Enable the consumer journey from physical card to digital payment methods (on-demand, secure, and seamless), meeting members' on-demand needs and eliminating the inconvenience of lost/stolen cards. •Single stacked card for all healthcare and commuter accounts. •Instant access to debit card upon enrollment or when requesting a new card. •Instant issuance generates card details on-demand from mobile app or website portal. •Digital wallet to push member credentials to Apple Pay, Google Pay, or Samsung wallet with a tap on the HealthEquity mobile app. **Enhanced Fraud Management** •Modernized card controls on mobile app (freeze card, usage controls). •Flag suspected fraudulent transactions. **Unified Mobile App** •Integrated mobile app across HSA, FSA, LPFSA and Commuter. •Unified view for members. **Advanced Technologies: Artificial Intelligence (AI)/Machine Learning** •Expedited claims processing for reimbursement accounts. •Limited Purpose FSA auto conversion when HDHP deductible is met. •Employer Performance Analyzer offers self-service analytics and engagement services to drive member and program outcomes using AI and machine learning technologies. •Data-driven engagement platform that leverages AI, insights, and personalization techniques to deliver tailored health and wellness recommendations. •Intelligent Spending leverages personalized claims data and AI to recommend cost-effective medical services with the goal of shared savings for both employers and members. •Benefits selection co-pilot. •Expanded options for adding a bank account for contributions/reimbursements
13f	How often are platform updates made to the employer portal?	13f	HealthEquity releases major product initiatives and system enhancements every 45 to 60 days throughout the year. Website updates, feature enhancements, and fixes are implemented throughout the year, according to a defined user acceptance test and release cycle. Updates or enhancements that impact the user experience are communicated in advance to partners, brokers, clients, and (if applicable), members. Updates are shared across a variety of key channels—depending on the scope of the enhancement. Channels include the employer and member sites, monthly statements, direct email communication, and partner and client webinars.
14	Do you have a mobile app for participant (member) use?	14	Yes
14a	Are there any major changes planned in the future to the mobile app, such as, but not limited to, software changes?	14a	Yes
14b	If Yes, please explain.	14b	**Unified Mobile App** •Integrated mobile app across HSA, FSA, LPFSA and Commuter. •Unified view for members.

14c	How often are updates made to the mobile app?	14c	HealthEquity releases major product initiatives and system enhancements every 45 to 60 days throughout the year. Website updates, feature enhancements, and fixes are implemented throughout the year, according to a defined user acceptance test and release cycle. Updates or enhancements that impact the user experience are communicated in advance to partners, brokers, clients, and (if applicable), members. Updates are shared across a variety of key channels—depending on the scope of the enhancement. Channels include the employer and member sites, monthly statements, direct email communication, and partner and client webinars.
15	Provide the following information about the company your organization partners with to provide FSA debit cards.	15	**Debit card partner details:**
15a	Name	15a	Fiserv
15b	Address	15b	600 N. Vel R. Phillips Avenue Milwaukee, WI 53203
15c	Phone number	15c	N/A
15d	Website address	15d	https://www.fiserv.com/en.html
15e	What qualifications or experience led you to choose this partner?	15e	Fiserv provides debit card production and transaction processing, fulfillment vendor for Quick Start Guides, explanations of benefits, and check/direct deposit.
16	Provide the following information about the company your organization partners with for FSA general banking services.	16	**Banking services:**
16a	Name	16a	
16b	Address	16b	As a matter of policy, we do not disclose the banks and financial institutions we operate with. HealthEquity maintains relationships with numerous banks.
16c	Phone number	16c	
16d	Website address	16d	
16e	What qualifications or experience led you to choose this partner?	16e	We have a procurement team that carefully vets all partners based on a distinct set of criteria.
16f	Are there multiple banks that you partner with for different services?	16f	Yes.
16g	If Yes was selected in response to Question 16f, please explain.	16g	As a matter of policy, we do not disclose the banks and financial institutions we operate with. HealthEquity maintains relationships with numerous banks.
17	The Vendor agrees to manage account activities including, but not limited to, claims substantiation, claims payment, account creation and termination, participant account or claims assistance, providing educational information and toll-free and online customer assistance. The Vendor agrees to manage all employer-level account activities including, but not limited to, establishing and processing various enrollment and payroll deduction files, providing educational information, terminating accounts established for ineligible Members, continuing program support services and toll-free and online assistance.	17	Yes, agreed to
18	The Vendor agrees that the City or its designated agent will be permitted to annually audit your performance under the contract, including, but not limited to, claims, customer service, banking and billing records.	18	Yes, confirmed
18a	If applicable, describe any deviations here:	18a	Not applicable.

	Section 3 - COBRA and FSA Compliance		Vendor Response
19	Confirm that your organization is in compliance with all federal, state, and local laws applicable to the services you would perform for the City.	19	Yes, agreed to
20	Describe how your company stays current with the latest COBRA, HCFSA, and DCFSA regulations to ensure programs remain compliant.	20	We maintain a formal program for legal and regulatory compliance review. Full-time compliance specialists and legal resources continuously monitor a variety of information sources and respond proactively to new legislation and regulations. We also review publications, newsletters, and trade journals related to benefits administration regulations and case law. New legislative requirements are immediately analyzed to determine the impact on our administrative services. Plans are then developed in a coordinated effort by legal, operations, product management, and IT staffs to ensure necessary changes are made to notices, systems, and procedures well before the effective date of a new provision. Internal personnel also perform regular audits of key systems and materials to ensure continued compliance.
21	The City may be obligated to comply with insurance regulations mandated by the State of California. Is the Vendor willing to comply, at no additional cost:	21	**California-specific regulations:**
21a	Implement and administer any current and future California state-mandated benefits that are not strictly health related; however, impact the administration of the COBRA, HCFSA, and DCFSA.	21a	No, deviation described below
21b	Provide a dedicated or designated resource to inform the City's benefits team about any applicable California state mandates in advance and to guide them through implementation, if requested.	21b	Yes, confirmed
21c	If Yes, will the resource be dedicated or designated?	21c	Designated
21d	If applicable, describe any deviations here:	21d	Any such implementation and administration of any current and future California state-mandated benefits will be considered on a case-by-case basis, and may incur additional costs.
22	Do you provide FSA Section 125 and Section 129 non-discrimination testing?	22	Yes, Section 125 and Section 129 Nondiscrimination Testing (NDT) are available services.
22a	If Yes, please describe the information needed to conduct the tests.	22a	HealthEquity offers non-discrimination testing for clients with reimbursement accounts. Although the IRS requires one testing session per plan year, our clients can request to test twice a year to maintain non-discrimination status. Additional fees may apply. We utilize a web-based service to conduct testing and results are usually processed within two to three business days. Upon client request, we provide testing guidelines, login credentials, and detailed instructions for accessing the required template. Templates request the following data: □ Employer identification data (used to designate the employer in our system). □ Plan start date. □ Employee identification data (name, date of birth, date of hire, officer status, union status). □ Shareholder voting power percentage. □ Ownership percentage. □ Compensation history. □ Hours worked per week/per month to determine part-time/seasonal status. □ Total pre-tax contributions made through the cafeteria plan, including employer-paid pre-tax premiums. Once the template is completed by the client, it is uploaded to a secure testing network. We send notifications when testing is complete and can review results with clients to adjust as necessary.

22b	If Yes, please describe when tests are typically run.	22b	Annually.
22c	If Yes, how long does it typically take for results to be provided?	22c	One test is included annually. Additional testing is available for $600.
22d	Is there an additional cost for this?	22d	Yes
22e	If there is an additional cost for this, please confirm that you have disclosed the charges/fees in the Pricings Worksheet.	22e	Yes, additional fees apply and they are disclosed in the Fee Exhibit

Section 4 - Data Security and Document Retention

Vendor Response

23	Confirm you are compliant with all HIPAA, EDI, privacy and security regulations	23	Yes, agreed to
24	What processes do you have in place in relation to Data Disaster Recovery? What redundancy is built into your data architecture systems if a major data center location is destroyed? What is the typical recovery time needed if backup files need to be employed to bring systems back online?	24	HealthEquity IT uses a suite of software monitoring tools in a 24-hour network operations center (NOC). Performance/availability alerting is aggregated through a centrally managed SIEM, which automatically notifies technicians of potential or actual incidents operating under a 45-minute service level standard to respond and restore service(s). Transaction auditing is accomplished through a combination of third-party software and HealthEquity proprietary event logging. All logs/audit files are written to a dedicated, secure logging server with limited access and are backed up nightly. HealthEquity's business continuity and disaster recovery plans are tested annually.
25	Please describe the types of controls in place to protect members from identity theft and medical insurance identity theft. Describe your policies and procedures for staff, third-party vendors, subcontractors, and outsourced vendors for working with Protected Health Information.	25	Our solutions are compliant with banking and HIPAA regulations regarding privacy and data security. One of our top priorities is to protect data from unauthorized use or disclosure. In accordance with HIPAA and other applicable legislation, we comply with legal requirements to curtail the distribution of protected health information and member data. We maintain SSAE-16 compliance and SOC2 Type II certification and perform HIPAA audits annually. Also, the servers that store personally identifiable information are kept in a secure environment. Additionally, our multiple levels of data security controls maintained include: □ Logical access controls including user sign-on identification and authentication. □ Data access controls (e.g., password protection of applications, data files and libraries). □ Accountability tracking. □ Anti-virus software. □ Secured printers. □ Restricted download to disk capability and provision for system backup. All employees are kept up to date on our security and privacy practices through annual training. Security reminders are continually provided to emphasize the critical nature of privacy in conjunction with necessary actions for protecting customer information.
26	Confirm that your organization is HITRUST certified.	26	No
26a	If Yes, please attach documentation.	26a	n/a
27	Please list the most recent date that your systems were reviewed and validated to ensure they comply with all current HIPAA regulations:	27	SOC 1, Type II, SOC2, Type II. Recent assessment occurred in November, and December of 2020, respectively.
28	Describe your compliance response should a breach of confidential data occur through your operations and areas of responsibility.	28	Our breach response policies and procedures create an organized approach to address and manage activities upon detection, during, and after a breach. Breach notification is governed by the Business Associate Agreement and is provided within 48 hours.
29	In the past five (5) years, have your systems been breached?	29	Yes
29a	If Yes, how did you respond to remedy the damages created by the breach?	29a	Yes, please refer to our recent SEC filing at: https://ir.healthequity.com/node/13631/html Prior to submission of this RFP, HealthEquity separately provided further details to the City of San Diego.

30	How would you categorize the safeguards you have in place within your enrollment, claim, and related systems to protect the privacy of members and their Protected Health Information (PHI)?	30	We comply with all HIPAA security and privacy rules. We also comply with any state regulations concerning data and patient privacy.
30a	If you have measures in place that are greater than what is required by law, please describe them.	30a	HealthEquity maintains controls which are intended to comply with applicable laws and regulations. HQY maintains SOC 1 Type II and SOC 2 Type II compliance which ic audited annually by an independent 3rd party.
31	Vendor confirms they can use an identifier (i.e., employee ID) other than the SSN at no additional charge.	31	Yes
32	Describe the internal controls your organization has in place to protect the security and privacy of participants, program data, and electronic and paper records.	32	Our solutions are compliant with banking and HIPAA regulations regarding privacy and data security. One of our top priorities is to protect data from unauthorized use or disclosure. In accordance with HIPAA and other applicable legislation, we comply with legal requirements to curtail the distribution of protected health information and member data. We maintain SSAE-16 compliance and SOC2 Type II certification and perform HIPAA audits annually. Also, the servers that store personally identifiable information are kept in a secure environment. Additionally, our multiple levels of data security controls maintained include: □ Logical access controls including user sign-on identification and authentication. □ Data access controls (e.g., password protection of applications, data files and libraries). □ Accountability tracking. □ Anti-virus software. □ Secured printers. □ Restricted download to disk capability and provision for system backup. All employees are kept up to date on our security and privacy practices through annual training. Security reminders are continually provided to emphasize the critical nature of privacy in conjunction with necessary actions for protecting customer information.
33	The Vendor shall provide forty-eight (48) hour turnaround or better on requests for access to information that is between three (3) years and five (5) years old, and seventy-two (72) hour turnaround or better on requests for access to information in machine readable form that is older than five (5) years.	33	No, not agreed to This is dependent on the type of request. Such requests are handled on a case by case basis and are subject to privacy and legal review and approval prior to release.
34	Vendor confirms that complaints and resolutions will be indexed and recorded for performance management and improvement, quality management, and general audit purposes.	34	Yes, agreed to

	Section 5 - FSA Banking and Administration		Vendor Response
35	Confirm that your organization can assume claims fiduciary liability.	35	No
35a	If applicable, identify any limitations that would be imposed on the City's decision-making process through this type of arrangement.	35a	Not applicable.
35b	If requested, would the City have the ability to override claim denials?	35b	Yes
35c	If there are additional fees or costs for this, please confirm that they have been disclosed in the City Pricing Worksheet.	35c	n/a
36	How often can you accept enrollment files and updates? Enrollment files are defined as file information with new participant enrollments, terminations, demographic and other changes, and any needed corrections. Please select the timing that most closely describes yours.	36	**Enrollment file timing:**
36a	HCFSA	36a	Immediately
36b	DCFSA	36b	Immediately
37	Does your organization have preferred standard electronic file templates? If Yes, provide details regarding the file format, and provide a sample for review.	37	Yes, the requested information is attached
38	Do you require your customers to use your file layout?	38	Yes
39	Describe your experience with, and capability to, accept claims feeds from various vendors (e.g., medical, dental, vision) and auto match claims, thus reducing the number of claims substantiation requests that a member would receive?	39	HealthEquity maintains integrations and data partnership with nearly 200 carriers and partners. We maintain data integration with most national providers and can work with you during implementation to establish any other integrations needed. We can receive data from the carrier to substantiate debit card transactions or to reimburse the participant for the out-of-pocket amount. To establish integration, the client gives authorization to the insurance carrier to include employee data in a file to us. If an existing relationship is not in place, we will work to establish integration with the carrier. We have a wide range of experience accepting data files from many combinations of health plan partner claims systems. There is no additional charge for electronic files submitted that adhere to our standard file specifications.
40	Can eligibility files for HCFSA and DCFSA products be uploaded at the same time or do you require a separate file upload per product?	40	Files for all products can be uploaded at the same time
40a	Can you provide the City with differing timing for different Classes? For example, can you provide the City with the ability to perform weekly eligibility file uploads and weekly account funding for Actives, and also to perform monthly eligibility file uploads and monthly account funding for pre-65 retirees.	40a	Yes

41	What additional digital and data processing resources would your organization require, if any, in order to fulfill the terms of your proposal?	41	N/A
42	How quickly are your FSA eligibility and claims systems updated upon receiving eligibility information? Please select the answer that most closely describes your timing.	42	1-2 days
42a	Once eligibility data is received, how quickly are welcome kits and debit cards mailed to the participant(s)? Please select the answer that most closely describes your timing. This question does not take into account USPS mailing time.	42a	Mailing occurs within 2-3 business days
43	Do you have the capability to provide the following timing option(s) for account funding?	43	**Account funding timing (Yes/No):**
43a	Custom	43a	Yes
43b	Daily	43b	Yes
43c	Weekly	43c	Yes
43d	Bi-weekly	43d	Yes
43e	Bi-monthly	43e	Yes
43f	Monthly	43f	Yes
43g	Can timing differ per product?	43g	Yes
44	Do you have the ability to provide the following timing option(s) for eligibility feeds?	44	**Eligibility feed timing (Yes/No):**
44a	Custom	44a	Yes
44b	Daily	44b	Yes
44c	Weekly	44c	Yes
44d	Bi-weekly	44d	Yes
44e	Monthly	44e	Yes
44f	Bi-monthly	44f	Yes
44g	Can timing differ per product?	44g	Yes
45	Once funds are wired, how long does it take for funds to be available to participants? Please select the timing that most closely describes yours.	45	1-2 days
45a	Does the timing differ per product?	45a	No
45b	If Yes, timing differs per product, please explain.	45b	No
45c	Do you provide an alternative to wire funding?	45c	No
45d	If Yes, alternative(s) to wire funding are available, please explain.	45d	No

46	Please describe any restrictions, limitations, and requirements the City must follow when funding accounts.	46	HealthEquity requires client pre-funding to ensure their FSA program(s) consistently have adequate funds to cover and quickly reimburse members' claims. Funding options seek to avoid any deficit in the client's prefund balances to ensure all member-approved claims are paid without interruption. Any excess balance of prefund amounts is returned after the end of the runout period each year or as otherwise directed by the employer. Funding options include: □ Reserve account invoicing: HealthEquity requests a percent of the total annual plan liability to be held on the employer's behalf as a reserve. This percentage varies based upon the funding frequency. Reserve funding will be requested at the beginning of each new plan year. Clients receive an emailed invoice identifying the amount to be replenished to meet the target percentage. This is the preferred method, providing the fastest means of claims payment. o Daily replenishment frequency: A 3% prefund amount and auto debit are required. o Weekly replenishment frequency: A 10% prefund amount (plans without debit card, such as dependent care FSA) or 15% (plans with debit card). o Monthly replenishment frequency: A 20% prefund amount (plans without debit card only). □ Pay as you go (with auto debit): each day if claim(s) are payable, an invoice is generated, and the account debited two business days later. This option is not available with a debit card. □ Fully funded: client will be invoiced for the total annual plan liability at the beginning of the plan year. □ Funding based on allocation files (dependent care FSA only): This option allows clients to fund the plan liability in conjunction with their payroll calendar. For dependent care FSA, the client is invoiced when deductions are submitted. Auto debit is not available.
47	Can you accept semi-annual HSA employer funding (half in January and half in July)?	47	Not applicable.
48	Describe the online account management tools available to the City. As part of your response, please provide log-in credentials and link to an administrator demo site for the City's review.	48	HealthEquity's client website provides tools needed to easily manage your plan. The employer portal delivers on-demand access to a robust suite of reporting, recordkeeping, and member management tools. The employer portal allows our clients to: □ Add new eligible employees and update existing member profiles □ Enter or change a healthcare or dependent care election □ Access management reports □ Cancel benefits □ Review file transfers □ Compare benefits funding and benefits payments □ Manage payroll deductions and other contributions □ Review administrative fees □ Provide access to other client representatives Click-through demo: https://www.healthequity.com/demo/welcome

Section 6 - COBRA and FSA Reporting and Analytics

Vendor Response

49	Can custom reports be created for COBRA and FSA administration?	49	Yes.
49a	Are there additional fees for custom reports? If Yes, please confirm that you have disclosed these fees in the City's worksheet.	49a	Yes, additional fees apply and they are disclosed in the Fee Exhibit
50	Please attach a list of standard reports that are available at no extra cost. Your list should include a brief description of each report as well as examples of standard reports.	50	Yes, the requested information is attached

51	Do you have the ability to provide benchmarking reports that will show the City's usage compared to other public sector entities in the same group size?	51	Yes

Section 7 - COBRA and FSA Account Management

			Vendor Response
52	Given that the City will be evaluating several proposals, describe why you feel that your services, from a professional and technical perspective, are the best fit for the City environment. Describe the distinguishing features the City should know about your services and company.	52	HealthEquity's COBRA solutions support tens of thousands of clients and participants nationwide, including the nation's largest private employer. With decades of experience, our COBRA solution in an industry stand-out for its: Flexibility: Flexibility is inherent in our system design. We offer hundreds of client options to customize our solution so we can meet the diverse needs of all clients across any industry. Proprietary Technology: Our integrated COBRA platform is maintained by full-time developers, programmers, and product specialists to administer changes, improve user experience, and enhance content. Secure Case Management: Our system allows clients and participants to submit and track COBRA inquiries through resolution. Clients have full transparency into participant cases online and can see where resolutions stand every step of the way. Real-Time Access: 24/7 access to real-time information, including a complete record of notices and history for employees and managers. Employers can track payments, major events, eligibility updates, and access on-demand reporting. Our self-service participant website provides participants the ability to review coverage information, make online payments, and request support. Transition Assistance: Our complimentary COBRA transition assistance program helps qualified beneficiaries easily find coverage alternatives. Our team of licensed benefit advisors help these beneficiaries know their COBRA rights and options. Compliance: We work closely with regulatory agencies, ERISA law firms, and industry groups to ensure our processes and systems remain in compliance. Our dedicated compliance managers monitor legislative and regulatory changes and work with our internal system developers to ensure our offerings meet the most up-to-date compliance regulations. Convenience: COBRA participants can make elections online, by mail, or toll-free fax. We deliver a variety of payment options, including online or by IVR, recurring ACH payments, or by mailed check.

53	Please provide bios for the COBRA and FSA account service team that would be assigned to the City.	53	**Louis Feinstein, COBRA Service Delivery Manager** Louis Feinstein has been with HealthEquity since October 2017. Lou's area of expertise is COBRA and Direct Bill administration on our proprietary software. Lou has a solid reputation of fast resolution due to familiarity with complex issues and varied processes and procedures. Lou is very detailed and has an ability to be a problem solver by analyzing the root of concerns. He is an avid New York sports fan and enjoys spending time with his wife and two sons. **Winston Revilla, FSA Service Delivery Manager** Winston Revilla joined WageWorks March 2018 as a Relationship Manager and has steadily built his client portfolio's and received among the highest results in client satisfaction ratings. He is currently managing 17 enterprise clients across the country. Winston brings with him more than 10 years of customer service experience, managing client relationships in the banking and finance industries. Winston's broad knowledge of industry services, products and marketing techniques support development of long-term consultative account strategies to increase product penetration. He will provide professional leadership and coordination of all activities, presenting potential solutions that align with long-term objectives. Winston's recommended solutions streamline processes, lower costs and ensure compliance. He will schedule onsite customer visits to monitor and improve the account status and customer satisfaction and respond to customer requests to analyze and resolve problems through identification and coordination of internal resources. Previously, Winston served as a branch manager with Washington Mutual Bank, now JP Morgan Chase, for over 15 years. He is located in California.
53a	Where is the office location for the COBRA account manager?	53a	Remote: Texas
53b	Where is the office location for the FSA account manager?	53b	Remote: California
54	Describe the account team's approach for escalating and resolving issues of importance to the City.	54	Service Delivery Managers strive to respond to non-urgent inquiries within one business day. A back-up contact is assigned when your assigned Service Delivery Manager is out of the office. An urgent request is defined as a situation that is time-sensitive, impacts a large group of employees, constitutes a large financial risk, or is deemed urgent by the client. If a client has an urgent request, it is recommended they email their Service Delivery Manager with "Urgent" in the subject line and contact them by phone. If the matter is urgent and the client does not receive a timely response (or less if it is a time sensitive matter) the matter will be escalated through leadership.
55	What is the turnover rate for your account managers in the last three years?	55	HealthEquity experienced 16.02% turnover in 2023 across all departments.
56	Will the day-to-day account manager be dedicated or designated?	56	Designated
56a	If Designated, please indicate how many other clients they will be managing.	56a	To ensure account management personnel can effectively service their clients, we employ a capacity planning model that evaluates client size and complexity (e.g., number of employees, number of accounts, number of enrolled participants, plan design complexity, number of HealthEquity programs and services, etc.) to determine resource allocation. This allows us to evaluate each client's needs to ensure we allocate necessary resources to meet expectations. While we anticipate that the number of clients supported will vary, your assigned Service Delivery Manager's book of business will be aligned with their tenure, experience, and acceptable capacity based upon the needs of their clients. With continued growth, HealthEquity expands and hires additional Service Delivery Managers to ensure each client's success.

Section 8 - COBRA Implementation

Vendor Response

57	Please provide a complete implementation plan, including personnel, timeline and tasks to be accomplished.	57	No implementation is required as HealthEquity is the incumbent for the services requested. However, please see **Attachment - Sample Implementation Timeline** for additional information.
58	Please indicate any other costs or fees associated with implementation with your company (i.e., start-up, eligibility, banking, etc.).	58	n/a

59	How much lead time will you need for the COBRA implementation?	59	n/a
60	Please provide an estimate of the type and amount of resources the client will need to ensure successful implementation.	60	n/a
61	During the implementation, please describe how current COBRA participants will be transferred over.	61	n/a

Section 9 - FSA Implementation

Vendor Response

62	Fully describe the process and timing needed for a successful implementation, including member transition/enrollment, claims and eligibility integration with the medical and pharmacy plans, setup of the employer portal, transition of funds and custodial/trustee responsibilities. Successful is defined as all systems being ready to go at least three (3) weeks in advance of the go-live date and for the implementation experience for the City's benefits team and plan members to be understandable, straightforward, and easy to follow. The implementation plan should include the following details:	62	**Implementation Plan:**
62a	Summary	62a	No implementation is required as HealthEquity is the incumbent for the services requested. We've successfully transitioned thousands of clients to our administrative services and rely upon our proven best practices to ensure implementation is smooth and efficient. During the sales process, each client is paired with a unique implementation team to oversee and manage the transfers between sales, the client, and all others involved. From initial kick-off to the final hand off, each specialized team coordinates with client benefits staff to identify requirements, complete a project plan, establish timelines, conduct meetings, coordinate with internal resources, and provide ongoing, proactive communication. When implementation is completed, each client works with their client services team for ongoing support.

62b	Account-level banking setup details	62b	HealthEquity requires client pre-funding to ensure their FSA/HRA program(s) consistently have adequate funds to cover and quickly reimburse members' claims. Funding options seek to avoid any deficit in the client's prefund balances to ensure all member-approved claims are paid without interruption. Any excess balance of prefund amounts is returned after the end of the runout period each year or as otherwise directed by the employer. Funding options include: □ Reserve account invoicing: HealthEquity requests a percent of the total annual plan liability to be held on the employer's behalf as a reserve. This percentage varies based upon the funding frequency. Reserve funding will be requested at the beginning of each new plan year. Clients receive an emailed invoice identifying the amount to be replenished to meet the target percentage. This is the preferred method, providing the fastest means of claims payment. o Daily replenishment frequency: A 3% prefund amount and auto debit are required. o Weekly replenishment frequency: A 10% prefund amount (plans without debit card, such as dependent care FSA) or 15% (plans with debit card). o Monthly replenishment frequency: A 20% prefund amount (plans without debit card only). □ Pay as you go (with auto debit): each day if claim(s) are payable, an invoice is generated, and the account debited two business days later. This option is not available with a debit card. □ Fully funded: client will be invoiced for the total annual plan liability at the beginning of the plan year. □ Funding based on allocation files (HRA and dependent care FSA only): This option allows clients to fund the plan liability in conjunction with their payroll calendar. For HRA, the client is invoiced as funds are added to the member's HRA. For dependent care FSA, the client is invoiced when deductions are submitted. Auto debit is not available.
62c	Participant-level setup details	62c	We accept FSA enrollments via: □ HealthEquity member portal (online enrollment by member or client representative). □ Enrollment files from the client sent in standard file specification formats or □ Toll-free enrollment with member service representatives (only if the client opts to enable online enrollment on the member portal).
62d	Points of contact	62d	Winston Revilla, as your current FSA Service Delivery Manager, will be your primary point of contact for FSA administration.
62e	Major tasks	62e	No implementation is required as HealthEquity is the incumbent for the services requested. However, please see **Attachment - Sample Implementation Timeline** for additional information.
62f	Data and program setup and configuration, file verification, and validation	62f	We have automated loading routines for standard formatted files, ANSI X-12 834 (A1), and other files. These processes poll for received files periodically, except where configured otherwise. These processes run continuously, except during planned system downtime performed within scheduled maintenance windows. The auto-load processes verify the schema of the file, and then test each record in the file, generating detail and summary test reports. Upon approval of the test results, the files are processed. Processing reports are queued and automatically distributed to the client's established EDI contacts. In the event that specific records have rejected on a file, a corrected file may be submitted, or the failing transaction(s) can be entered manually by the client to our client website portal.
62g	Testing of eligibility files and claims files including logic	62g	When implementing a new inbound file, HealthEquity relies on systems and processes to test new files. We can test either a partial or full file. Testing is completed to confirm the fit and format and depending on the file type may involve scenario testing.
62h	Debit card production and mailing	62h	New hires and/or new members can expect to receive their debit card within ten to 15 calendar days after the employer's enrollment file is successfully loaded. (For a January 1 benefit month, we suggest allowing up to three weeks for this process.) Since open enrollment season is the busiest time of year for card production and the U.S. Postal Service, a clean enrollment file must be provided and loaded to HealthEquity by the beginning of December to ensure standard cards are issued timely.

62i	Constraints and/or risks	62i	One of the most important lessons learned is making sure that ample time is allowed for developing and delivering member communications to make informed decisions regarding their benefit elections and how to access those benefits with HealthEquity. The range of benefit understanding among employees varies, so providing targeted, concise, and accessible program information is important in helping members maximize their benefits. We accomplish this with a library of pre-built materials accessible through multiple mediums, as well as options for custom solutions. We make it a point to identify the appropriate stakeholders of the program and include them during the implementation process to maximize the impact of these communications. We also offer training sessions to our clients' benefits team to help them understand how our program operates and prepare them to educate and support their employees. We have created easy-to-use presentations and other handout materials to support your benefits team. These materials help both your employees and your benefits team understand the intricacies of each program which help employees make informed decisions while maximizing those benefits. The communication approach we have developed has proven to be very successful. When leveraging our education program, we have found increase in member contributions. Additionally, following participation in our webinars, nine out of 10 participants indicated a likelihood to enroll in the benefit presented. In addition, program understanding, and engagement increases employee satisfaction with their benefits.
62j	Issue elevation and resolution protocol	62j	Winston Revilla, as your current FSA Service Delivery Manager, will be your primary point of contact for FSA administration.
62k	Will the implementation manager be dedicated or designated?	62k	Not applicable. No implementation is required as HealthEquity is the incumbent for the services requested.
62l	If Designated, please indicate how many other implementations they will be managing.	62l	Not applicable. No implementation is required as HealthEquity is the incumbent for the services requested.
63	Describe your process for transferring accounts and assets from another administrator.	63	Not applicable. No implementation is required as HealthEquity is the incumbent for the services requested.
64	What is your standard blackout period and how do you handle member communications beforehand?	64	Not applicable. No implementation is required as HealthEquity is the incumbent for the services requested.
65	The City utilizes the following systems/vendors. Please indicate if you have an established relationship and history of working with these systems/vendors and provide references.	65	**Integration (Yes/No):**
65a	Payroll vendor: Internal	65a	Yes, we are very experienced with this platform and have a strong working relationship
65b	Benefits administration: Internal	65b	Yes, we are very experienced with this platform and have a strong working relationship
65c	Medical: Cigna	65c	Yes, we are very experienced with this platform and have a strong working relationship
65d	Medical: Kaiser	65d	Yes, we are very experienced with this platform and have a strong working relationship
65e	Medical: Sharp	65e	Yes, we are very experienced with this platform and have a strong working relationship
65f	Dental: Delta Dental	65f	Yes, we are very experienced with this platform and have a strong working relationship
65g	Vision: Vision Service Plan	65g	Yes, we are very experienced with this platform and have a strong working relationship
66	How much time will you require after the effective date to issue administrative materials to the City, plan document, and a master contract?	66	The initial plan document and summary plan description are included at no cost when a setup/implementation fee is charged. Updates to these documents are available for an additional fee.

67	Describe all support and resources provided during open enrollment.	67	Engage360 is our scalable, year-round member engagement program designed to deliver the right message to the right member at the right moment. Our proactive, ongoing, and targeted programs help members get more from their healthcare dollars while relieving healthcare costs. Through our exclusive behavior-based email campaigns, we engage members with targeted content relevant to their benefit choices. All emails, message center posts, and showcased images on our member portal pages are created to inform, educate, and inspire members. Engage360 also features a robust digital gallery of content, tools, and insights proven to drive adoption, maximize utilization, and measure success. Our Engage360 library contains fully customizable content for our clients that includes: □ Newsletter articles □ Blogs □ Posters □ Digital ads □ Postcards □ Flyers (available in English and Spanish) □ On-demand webinars 24/7 □ Mobile-friendly emails, learning sites, and postcards We also offer new client boot camps to help employers boost early member engagement. Bootcamps include: □ Client website portal webinars □ Member resources □ Open enrollment toolkit □ Education and engagement tools □ Best practices
68	Outline your preferred approach to the open enrollment process and any specific requirements including frequency and duration.	68	HealthEquity maintains dedicated resources to encourage program participation through intentional, measured employee education outreach. As part of this effort, we incorporate best practices and expertise in support of benefit fairs, open enrollment meetings, webinars, and presentations to foster employee education, appreciation, and utilization of benefit programs. Our website houses a variety of resources, including videos and tutorials available to employees at any time. We also provide year-round webinars focused on specific topics, including: □ Qualified medical expenses □ Claims reimbursement □ Maximizing tax advantages □ Open enrollment □ Income tax deadlines Our education personnel can also provide on-location support to encourage program participation and enhance understanding of reimbursement account benefits to employees.

69	Describe the proposed implementation team and outline their roles, areas of expertise, and indicate the length(s) of time they will be assigned to the account.	69	Not applicable. No implementation is required as HealthEquity is the incumbent for the services requested. A designated implementation team is responsible for providing clients with a seamless transition to our services. The implementation team coordinates with the client's benefits staff to establish implementation requirements, schedule, and participate in a kick-off meeting, complete and maintain a project plan and action log, establish timelines, identify action items and requirements, coordinate with internal resources, and provide updated and timely communications. The implementation team includes an implementation manager and a service delivery manager and will be supported, as needed, by other internal HealthEquity subject matter experts such as technical integrations, marketing, fulfillment, etc. The implementation manager will take the lead in identifying the need for, requesting, and coordinating with those additional HealthEquity subject matter experts. Upon completion of the implementation, the client will be transitioned to a service delivery manager, who is already familiar with your benefit offering, for ongoing account management and administration.

	Section 10 - FSA Participant Experience		Vendor Response
70	Please provide the following statistics about your call center for the most recent two years:	70	**Call center statistics:**
70a	2023, 2022	70a	Please see below:
70b	Total number of inquiries handled	70b	2023: 6,589,468, 2022: 3,702,846
70c	Average hold time	70c	2023: 23 seconds, 2022: 20 seconds
70d	Call abandonment rate	70d	2023: 2.57, 2022: 2.44%
70e	Percentage of inquiries resolved during the initial call	70e	2023: 94.21%, 2022: 93.33%
70f	Total number of email inquiries	70f	2023: 240,251, 2022: 330,774
70g	Average number of days for email inquiry resolution	70g	Our standard turnaround for responding to and following up on member issues is one to two business days.
70h	Total number of chat inquiries	70h	2023: 791,709, 2022: 454,978
70i	Do customer service representatives have access to real-time participant account and claim information?	70i	Yes.
71	We'd like to learn more about your system of record for storing and documenting participant (member) communications and interactions with your various teams. Please provide responses below about the characteristics of the tracking & record-retention systems utilized by your customer service teams.	71	**Customer service systems capabilities (Yes/No):**
71a	Stores date, time, and length of calls	71a	Yes
71b	Tracks multiple inquiries for the same or similar issues	71b	Yes
71c	Records all calls	71c	Yes
71d	Provides autogenerated call reference numbers	71d	Yes
71e	Stores what was communicated to the member	71e	Yes
71f	Stores what the member communicated	71f	Yes
71g	Tracks inquires by date	71g	Yes
71h	Tracks inquires by reason	71h	Yes
71i	Tracks inquires by urgency	71i	Yes
71j	Tracks by issue being resolved or unresolved	71j	Yes
71k	Automatically routes unresolved issues to the appropriate team	71k	Yes
71l	Automatically routes calls to the appropriate team	71l	Yes
71m	Automatically alerts management of escalated issues	71m	Yes
71n	Are customer service contact phone numbers clearly labeled and displayed?	71n	Yes
72	Can customer services representatives make adjustments to a claim during a phone call with a participant?	72	Yes, Member Services can assist callers with providing the appropriate required claims data.

73	What are the normal hours of operation for the customer service team that would handle member phone calls?	73	24/7/365
73a	Can members access the customer service team by email?	73a	Yes
73b	Can members access the customer service team via a chat function?	73b	Yes
73c	Can members access the customer service team via text?	73c	No
73d	Is customer service 24/7?	73d	Yes
74	Do you have a bilingual (English and Spanish) call center?	74	Yes. HealthEquity uses a third-party translation service to support non-English-speaking callers. With this service, we can access U.S.-based interpretation support for more than 150 languages.
75	What type of ongoing training do customer service representatives receive?	75	All new member service representatives participate in three weeks of group and individual learning. This advanced training focuses on product, user platforms, and company knowledge. Training includes: □ Instructor-led lectures □ Interactive media □ Skill assessments □ Classroom discussion □ Mentoring with experienced staff Following classroom training, the representative undergoes two weeks of “hand holding” where the new representative takes a small number of calls with observation by their supervisor and HealthEquity’s Learning and Development team. New team members must complete an observation period, perform assisted call answering, and pass a comprehensive exam.
76	Does your call management system inform callers of their anticipated wait time and provide the option for a call back?	76	Yes
77	Describe available support for individuals who do not have online access.	77	Member Services are available via phone.

Section 11 - COBRA and FSA Digital Tools

Vendor Response

78	Describe any mobile apps (compatible with iPhone and Android) currently available to your COBRA and FSA benefits that are available as a part of your standard pricing.	78	COBRA HealthEquity offers a mobile-optimized website that provides COBRA participants access to their account information anytime, anywhere. Participants can review current coverage, check payment history, make online premium payments, view notices and messages, and access helpful resources and contact information from the mobile website. The mobile website is optimized for mobile devices, regardless of smart phone or tablet type. FSA HealthEquity’s mobile application allows members to manage their accounts on the go. The app is available on iOS and Android platforms. Through the app, members can perform most functions that are available online, including: □ View transactions, claim activity, and account balance. □ File a claim for reimbursement. □ Schedule direct payment to providers. □ Snap a photo of receipts. □ Substantiate debit card claims with receipt documentation or substitute receipts. □ Access account statements. □ Verify product eligibility for HSA, FSA, or HRA with a barcode scanner. □ Review coverage periods and claim deadlines for current accounts. □ View and edit account profile and communication preferences. □ Sign up for direct deposit. □ Chat with member service representatives 24/7.

79	Is your website available in English and Spanish?	79	No
80	Is your website available in other languages?	80	No
80a	If Yes, please provide details.	80a	HealthEquity continues to focus on delivering a remarkable experience to all members and clients. While our tools are built in English, we minimize the use of images to allow for in-browser translation services to help people self-serve in multiple languages.
81	Is your mobile app available in English and Spanish?	81	No
82	Is your mobile app available in other languages?	82	No
82a	If yes, please provide details.	82a	HealthEquity continues to focus on delivering a remarkable experience to all members and clients. While our tools are built in English, we minimize the use of images to allow for in-browser translation services to help people self-serve in multiple languages.
83	We would like to ensure that your website is accessible to users with disabilities by ensuring easier navigation. Please indicate whether or not the following features are readily available:	83	**Assistive capabilities (Yes/No):**
83a	Users are able to navigate using screen readers and the keyboard	83a	Yes
83b	Uses visible "skip navigation links" allowing users to navigate content without a mouse	83b	No
83c	Clear and descriptive labeling on links and buttons	83c	Yes
83d	Text captions for videos	83d	Yes

Section 12 - FSA Communications

Vendor Response

84	Describe your strategic approach to encourage spending account plan participation including available member engagement communication materials and content (turnkey and customizable). Ensure that your suggested approach incorporates resources available as a part of your standard pricing package only.	84	**Communications strategy:**
84a	HCFSA	84a	Engage360 is our scalable, year-round member engagement program designed to deliver the right message to the right member at the right moment. Our proactive, ongoing, and targeted programs help members get more from their healthcare dollars while relieving healthcare costs.
84b	DCFSA	84b	
85	Please provide copies of your reimbursement request form, explanation of payment form, health care balance summary report, and participant activity statements ("Participant forms").	85	Yes, the requested information is attached
86	Confirm your ability to have staff attend benefit fairs as requested by the City. The cost of attendance and travel shall be borne by the Vendor.	86	No, deviation described below
86a	If deviations apply, please describe them.	86a	HealthEquity offers a total of 5 days onsite at no cost. Additional days will be incur costs and travel expenses.
87	Vendor agrees that they are willing and able to prepare and present live webinars for plan participants and/or for benefits staff, as requested.	87	Yes, confirmed
87a	If deviations apply, please describe them.	87a	Not applicable.

88	The Vendor confirms that they agree to host in-person meetings and provide printed training materials as needed.	88	No, deviation described below
88a	If deviations apply, please describe them.	88a	HealthEquity offers a total of 5 days onsite at no cost. Additional days will be incur costs and travel expenses.
89	List the standard communications and educational materials available at no extra cost. Your list should include a brief description of each item.	89	Engage360 is our scalable, year-round member engagement program designed to deliver the right message to the right member at the right moment. Our proactive, ongoing, and targeted programs help members get more from their healthcare dollars while relieving healthcare costs. Through our exclusive behavior-based email campaigns, we engage members with targeted content relevant to their benefit choices. All emails, message center posts, and showcased images on our member portal pages are created to inform, educate, and inspire members. Engage360 also features a robust digital gallery of content, tools, and insights proven to drive adoption, maximize utilization, and measure success. Our Engage360 library contains fully customizable content for our clients that includes: □ Newsletter articles □ Blogs □ Posters □ Digital ads □ Postcards □ Flyers (available in English and Spanish) □ On-demand webinars 24/7 □ Mobile-friendly emails, learning sites, and postcards We also offer new client boot camps to help employers boost early member engagement. Bootcamps include: □ Client website portal webinars □ Member resources □ Open enrollment toolkit □ Education and engagement tools □ Best practices Electronic materials are included. Printing and shipping may result in extra cost depending on scope of materials requested.
90	Provide sample materials or communications that you provide to employees detailing debit card benefits and functionality (e.g. flyer, brochure, video) as a part of your standard pricing.	90	Yes, the requested information is attached
91	What type of member communications do you provide regarding annual claim filing deadlines and forfeiture rules? Describe the general language and communication method(s) used, e.g. paper mail, email, text, etc.	91	HealthEquity issues a year-end balance reminder to members who have a balance greater than $20 in their FSA/HRA account prior to the end of the plan year. For clients that have enabled the carryover feature for their plan, notices are issued if the balance is greater than the carryover amount. The communication reminds and encourages members to use all their remaining funds from their account. If a member has an email address on file, the year-end reminder is sent electronically. Otherwise, the communication is mailed to the member's home address.
92	What type of communications do you provide regarding account balances? Describe the general language and communication method(s) used, e.g. paper mail, email, text, etc.	92	If a member has an email address on file, the year-end reminder is sent electronically. Otherwise, the communication is mailed to the member's home address.

93	Outline your preferred approach to the open enrollment process and any specific requirements.	93	HealthEquity typically receives enrollment information from the client via electronic file transfer. Upon processing eligibility and enrollment data received from the client, HealthEquity mails welcome materials to employees enrolled in the FSA. Welcome materials include debit card (when applicable), instructions for accessing the member portal, contact information for member services, and tips for maximizing health savings with an FSA. If electronic enrollment confirmation is elected by the client during implementation, HealthEquity can also email a confirmation statement to the member within minutes once the file loads into our system.
94	Describe all communications support and resources provided during open enrollment as part of your standard pricing.	94	Engage360 is our scalable, year-round member engagement program designed to deliver the right message to the right member at the right moment. Our proactive, ongoing, and targeted programs help members get more from their healthcare dollars while relieving healthcare costs. Through our exclusive behavior-based email campaigns, we engage members with targeted content relevant to their benefit choices. All emails, message center posts, and showcased images on our member portal pages are created to inform, educate, and inspire members. Engage360 also features a robust digital gallery of content, tools, and insights proven to drive adoption, maximize utilization, and measure success. Our Engage360 library contains fully customizable content for our clients that includes: □ Newsletter articles □ Blogs □ Posters □ Digital ads □ Postcards □ Flyers (available in English and Spanish) □ On-demand webinars 24/7 □ Mobile-friendly emails, learning sites, and postcards We also offer new client boot camps to help employers boost early member engagement. Bootcamps include: □ Client website portal webinars □ Member resources □ Open enrollment toolkit □ Education and engagement tools □ Best practices Electronic materials are included. Printing and shipping may result in extra cost depending on scope of materials requested.

Section 13 - FSA Debit Cards

Vendor Response

95	Provide an illustration of your standard debit card.	95	Yes, the requested information is attached
95a	Are custom debit cards available? If Yes, please confirm that you have disclosed these fees in the Pricing Worksheet.	95a	Yes, additional fees apply. We will be pleased to discuss branding and messaging options and associated pricing with you based upon further understanding of your specific needs.
95b	If Yes, describe the customization options available to the City.	95b	HealthEquity can accommodate customization of its debit card. We offer multiple card customization options that can include co-branding, custom messaging, or full customization. All customizations must be approved by both the issuing bank and the card association (Visa). We manage the customization approval cycle on behalf of the client. We will be pleased to discuss branding and messaging options and associated pricing with you based upon further understanding of your specific needs.

96	Describe all safeguards placed on debit cards to prevent cards use for non-qualified expenses.	96	Yes, additional fees apply. We will be pleased to discuss branding and messaging options and associated pricing with you based upon further understanding of your specific needs.
97	How many cards do you make available per accountholder by type of account?	97	At the time of enrollment, we automatically issue a debit card to the member and their spouse (if applicable). Members can order additional cards for dependents by contacting our member services team by toll-free phone 24/7 or online through the member portal. Up to three debit cards are provided to members at no cost. There is a member-paid fee of $5.00 for each subsequent card requested.
98	Are members notified when a suspended debit card is reactivated? Other than claim substantiation or repayment, are there other events that will activate a deactivated debit card?	98	HealthEquity offers multiple options for handling card suspension for unsubstantiated claims. These options are reviewed with clients during the implementation process. Clients can select from the following options: □ No suspension: HealthEquity continues to request substantiation documentation from the member via email, if on file, or mailed notice. With this plan option, the card remains active regardless of transaction status. □ Suspend at 90 days and unverified balance is above threshold (best practice): This threshold is set at a client-determined amount/ percentage of available balance (the system default is 50%). With this option HealthEquity continues to request substantiation documentation from the member via email, if on file, or mailed notice. The card is reinstated after the unverified total is below the threshold percentage. Cards will be reactivated at the beginning of new plan year. □ Suspend at 90 days and when unverified balance is above threshold: The card can be suspended at 90 days or when the unverified balance exceeds the client-defined threshold (between 1% to 99%) of the available balance. The threshold is set at a client-determined amount/percentage of available balance (the system default is 50%). With this option, HealthEquity continues to request substantiation documentation from the member via email, if on file, or mailed notice. The card will be reinstated only after all unverified transactions are cleared. If the card is suspended at the end of the plan year, it will remain suspended across plan years. The best-practice approach will be implemented unless otherwise approved by HealthEquity. HealthEquity will continue to request substantiation from the member for each unverified transaction (less than 20% of all transactions on average). If we are unable to substantiate a card transaction within five days (20 days if carrier files are provided), members are sent notification via email, if on file, or mail. If the card is in a suspended status, HealthEquity will automatically offset approved claims for reimbursement to resolve unverified card transactions, allowing repayment of the unverified amount to the account. Card privileges will be automatically reinstated within two business days once the verification requirements have been met.
99	At a minimum, the Vendor shall offer account holders the following reimbursement methods: debit card, online bill pay, check reimbursement and direct deposit.	99	Yes, agreed to
100	Are the debit cards chip-enabled?	100	Yes
101	How are the debit cards activated?	101	Each debit card is assigned unique activation information to authenticate the member and change the status of the card to issued. If the card is not initially activated, it remains in a pending activation status until either the member activates the card or the member no longer has an active plan. Service representatives are available to members that experience issues with or have questions about the card activation process.
101a	What safeguards are in place to protect against fraudulent activation (e.g. the wrong person receiving the debit card and activating it)?	101a	HealthEquity proactively monitors card transactions to identify suspicious trends. We take appropriate actions to remediate any identified issues with the member as needed. We use monitoring tools that result in real-time declines based on activity that is deemed suspicious. False positive rates are tracked to minimize the impact on valid transactions. HealthEquity will proactively reissue cards to impacted members if a merchant identifies a breach of their database or card terminal or if we identify a suspicious trend indicating the card is likely compromised.
102	Can the same debit cards be utilized for all products?	102	No. We do not allow the use of our debit card to pay for dependent care expenses. Due to IRS regulations and payment policies of most dependent care centers, HealthEquity and most FSA administrators have found that dependent care debit cards do not create a member-friendly experience. Rather, we offer direct payment to dependent care providers, as well as reimbursement to members for eligible dependent care expenses.
103	Does the City have the option to issue separate cards for each product?	103	No. We do not allow the use of our debit card to pay for dependent care expenses. Due to IRS regulations and payment policies of most dependent care centers, HealthEquity and most FSA administrators have found that dependent care debit cards do not create a member-friendly experience. Rather, we offer direct payment to dependent care providers, as well as reimbursement to members for eligible dependent care expenses.

103a	If Yes, please confirm that you have disclosed these fees in the Pricing Worksheet.	103a	n/a

	Section 14 - FSA Substantiation		Vendor Response
104	Explain your ability to provide the City, if requested, copies of any notifications that you may send to our employees after a debit card transaction is not substantiated, as well as what must happen before a debit card is deactivated.	104	Depending upon service features the member has enrolled in, HealthEquity provides email notifications and online messaging requesting debit card substantiation from the member. Messaging is also provided on the member website and mobile app indicating that a card transaction requires substantiation. If an email address is not provided for the member, they may receive a written communication requesting substantiation and notice of possible suspension (if that option is selected by San Diego.)
105	What mechanisms do you have in place to auto-substantiate a member's copays, coinsurance, or deductible expenses at a pharmacy or provider's office to limit the number of claim substantiation requests a member would receive?	105	Our proprietary adjudication engine reviews all debit card transactions to ensure compliance with IRS regulations while using a comprehensive checks and balances system to protect against fraud. We limit card use to locations associated with approved healthcare-related merchant categories. Next, the system verifies that the transaction is for an eligible healthcare product or service. Once the merchant and purchase eligibility are confirmed, the system verifies that the card is activated, the authorization date of the transaction falls within the member's coverage period, and the transaction amount does not exceed the account balance. Once the system verifies these criteria, our adjudication engine uses the following methods allowed by the IRS to automatically substantiate debit card transactions: □ Inventory Information Approval System (IIAS) auto adjudication: system confirms eligibility of items purchased at point of service; □ Copayment Logic: Auto-approves health plan copayment amounts provided by program sponsors; □ Recurring Transaction Logic: Once a card transaction is substantiated with a receipt, any card transaction in the same dollar amount at the same merchant location is automatically substantiated for 12 months □ Carrier Files: Medical, dental, pharmacy, and vision carrier files may be used to verify expenses Using these processes, HealthEquity successfully auto adjudicates nearly 90% of card transactions across our FSA, HRA, and HSA members.
106	How quickly do processed claims show up on the participant (member) portal? Please select the timing that most closely describes yours.	106	Immediately
107	The Vendor agrees to handle all processes related to the substantiation and payment of claims in compliance with IRS rules. The Vendor agrees to notify the City in a timely manner of any improper payments that cannot be substantiated or recovered.	107	Yes, agreed to
108	Describe the types of substantiation documentation required for the following types of claims:	108	**Claim substantiation documentation:**
108a	HCFSA	108a	Claims processors review claims to ensure required data and documentation are provided for adjudication. For healthcare services, receipts, provider statements, and explanation of benefits can be provided as substantiation when accompanied by a completed claim form. The following data are required for health care FSA claims approval: □ date service was provided, □ type or description of service provided, □ name of the service provider, □ name of the patient/dependent, and □ amount of the expense incurred. For expenses not covered by health insurance (e.g., deductible), an itemized statement from the provider is required with the patient's name, date of service, procedure description, provider name, and charge for the service. For prescription drugs, a pharmacy statement, including the name of the pharmacy, patient's name, date of fill, cost, pharmacy number, and name of the drug is required.

108b	DCFSA	108b	For dependent care FSA claims, supporting documentation must include: □ dependent's name, □ provider's name, □ Description of service provided, □ provider's ID signature or receipt (not both), □ date of service, □ dollar amount of eligible services, and □ participant's signature on the claim form.
109	Describe the following about your processes and procedures for recovering overpayments:	109	**Overpayments:**
109a	General processes and procedures for recovering overpayments	109a	HealthEquity utilizes a single funding account concept per member for all claims, card transactions, and direct payments. The balance of this account is updated in real-time prior to any fund disbursement. As a result, overpayments are exceedingly rare. Should a claim payment need to be corrected or recouped, HealthEquity provides a communication to the member with clear instructions on how to correct the claims error. Account repayment is typically facilitated via a check, or where a vendor card transaction took place, we accept and process credits back onto the debit card. Where appropriate, payroll funding reversals may be provided on the client's funding file for processing.
109b	When are communications sent to the participant?	109b	Should a claim payment need to be corrected or recouped, HealthEquity provides a communication to the member with clear instructions on how to correct the claims error.
109c	How are communications sent to the participant (e.g. text, mail, email, mailed letter)?	109c	HealthEquity can communicate with members via email, if on file, or mailed notice.
109d	Are there any circumstances in which additional fees would be charged for processing overpayments?	109d	No
109e	If Yes, please confirm that you have disclosed the additional costs in the Pricing Worksheet.	109e	n/a
110	Describe the following about your processes and procedures for ineligible claims:	110	**Ineligible claims:**
110a	General processes and procedures for ineligible claims:	110a	Claims are denied for reasons such as duplicate submissions, non-eligible items, or missing information. If a claim is denied, we send members a letter detailing why we could not process their claim.
110b	When are communications sent to the participant?	110b	Immediately.
110c	How are communications sent to the participant (e.g. text, mail, email, mailed letter)	110c	HealthEquity can communicate with members via email, if on file, or mailed notice.
110d	Are there any circumstances in which additional fees would be charged for processing ineligible claims?	110d	No
110e	If Yes, please confirm that you have disclosed the additional costs in the Pricing Worksheet.	110e	n/a
111	Describe your claim investigation process for each product listed below.	111	**Claim investigations:**
111a	HCFSA	111a	Claims are processed according to Internal Revenue Service regulations. An eligible expense list is configured into our system to assist in the
111b	DCFSA	111b	adjudication process. Claims processors closely scrutinize claims to ensure eligibility. During this process, claims are reviewed for service
111c	Are there any circumstances in which additional fees would be charged for claim investigations?	111c	No
111d	If Yes, please confirm that you have disclosed the additional costs in the Pricing Worksheet.	111d	n/a

112	Do you have a standard minimum dollar threshold that must be reached before claims are reimbursed?	112	Yes
112a	If Yes, please provide details.	112a	$0.01
113	Do you provide run-out claim adjudication in the event of termination of your contract?	113	Yes
113a	If Yes, please describe the available options.	113a	We will administer the plan based on the client's requirements and run-out policies. Our system allows us to set up a plan as a calendar year, setting claims run out, based on the number of days or months from coverage or plan end. This setup supports claims controls on a plan year basis. Alternately, we can set up a perpetual plan, which allows members to file claims incurred from prior years back to their original coverage start date. Clients can determine run-out provisions for mid-plan coverage end dates. Admin Fees are charged throughout run-out, carry-over and grace periods for all plan years including the last plan year of the contract.

Section 15- COBRA Administration

Vendor Response

114	What office/location would be responsible for providing COBRA administration?	114	HealthEquity is headquartered in Draper, Utah and maintains an operations center in Irving, Texas. Additionally, we maintain a remote workforce nationwide with remote employee concentrations in the Salt Lake City, Utah; San Francisco, California; Louisville, Kentucky; Minneapolis/St. Paul, Minnesota; Dallas, Texas; Seattle, Washington; and Phoenix, Arizona markets.
115	What are the hours for COBRA customer service?	115	COBRA and Direct Bill participants receive toll-free access to service representatives 12 hours per day, Monday through Friday (excluding holidays) from 8:00 a.m. to 8:00 p.m. Eastern Time. Additionally, COBRA participants can access our interactive voice response (IVR) system and website for real-time information and convenient access to accounts.
116	Can you process health care FSA contributions from terminated employees on COBRA?	116	Yes

117	Describe your COBRA administration system.	117	We provide comprehensive COBRA administration solutions for employers. The procedures used are based upon best practices gleaned from years of administrative experience and industry expertise. COBRA administration processes include: General Rights Notification We can provide general rights notifications to newly covered employees. Upon receipt of newly covered employee data from the employer, COBRA general rights notices are generated by the COBRA system and mailed via first class mail. The notices are imaged and retained within the proprietary COBRA system. As an option, we can also provide a retroactive COBRA rights notification service to ensure the employer's entire population is in compliance with this requirement. Qualifying Event Notification We issue compliant COBRA election notices to qualified beneficiaries upon receipt of qualifying event information from the employer. Employers can notify us of qualifying events by electronic file transfer or by entering qualifying event data into the COBRA system via the website. Upon processing of the qualifying event from the client, our proprietary system issues a qualifying event/COBRA election notice. These notices are issued within two business days following file processing or immediately for qualifying event updates provided by the client via website. Notifications include customized coverage options and instructions regarding electing continuation via Internet or paper election forms and are mailed via USPS first class mail. An image of the issued notification is available on our website. We understand the financial impact COBRA continuants have on a benefit program, with COBRA claims representing 153% more claim utilization than active employees. To help address these financial risks to the employer, as well as helping to educate former employees, we provide at no cost a joint publication to help educate qualified beneficiaries regarding their COBRA alternatives and options. Through a seamless COBRA transition assistance program, we provide COBRA qualified beneficiaries with important information to aid in their decision-making process. We supply materials that can be provided to employees when they or family members lose coverage and become eligible for COBRA. The COBRA transition assistance service also includes access to a team of licensed benefit advisors who can answer questions about insurance coverage, helping individuals and families find the best coverage at a price they can afford. Billing and Collection We bill COBRA premiums via monthly invoices mailed to participants. We collect premium payments from COBRA continuants monthly by mail, phone, or online, and reconcile receipts within our system. All incoming premium checks are received and processed by a financial institution lock box. All checks, remittance slips, envelopes and any other documentation received are imaged and provided to HealthEquity. The financial institution uses a daily file of participant account statuses and compares checks received against this file for deposit ability. Checks received with a premium remittance slip are processed against the participant account statuses. Checks that pass this process are cashed. Checks that should not be cashed due a participant's account being terminated are flagged. These checks are returned by the financial institution to the participant with a letter explaining the reason for the return. If a check is received without a remittance slip, it is
118	What is your process when correspondence, notices, premium statements are not deliverable? Please explain separately related to initial notifications, qualifying event notices, termination of coverage notices, premium statements, non-payment of premium notices.	118	Our return mail process tracks all returned mail pieces and notifies the client by website reporting and/or email. Clients are encouraged to review these reports and verify that the addresses used on these mailings represent the last known address as per COBRA requirements. From the return mail report, the client has the option to have us resend the requested notifications for participants who are still active. Invoices are mailed monthly and reflect any past due premiums within the client-specified grace period. As an option, clients can choose to have a past due notice issued via mail for an additional fee. HealthEquity offers a variety of methods to ensure participants understand important account information, such as premium due dates. Participants can also evaluate premium due dates by reviewing imaged notices or real-time account information from the participant website. Premium due dates are available on the toll-free interactive voice response (IVR) as well. A qualified beneficiary has 45 days after the date on which they elected COBRA to make an initial payment. After the initial payment, COBRA premiums are subject to a 30-day grace period after the due date. Configurable client options are available if the client wishes to offer more lenient grace periods. Premium payments not received within the grace period result in coverage cancellation.
119	Do you typically use certified mail to send initial notification and qualifying event notices?	119	Yes

120	Do you send separate eligibility notices to spouses and dependent children living at separate addresses?	120	Yes. To the extent requested by the client, participant notices (such as the COBRA general notice and COBRA election notice) are furnished via USPS first-class mail to the covered employee's last-known mailing address and to the covered spouse and dependent children, if applicable. If the employee and spouse (or qualified beneficiaries, in the event of a COBRA election notice) reside at the same address, COBRA regulations authorize use of a single notice to all such individuals residing at the same location. If we are notified that a covered spouse or dependent child resides at a different address from that of the covered employee, we will, to the extent requested, furnish a separate participant notice to the dependent's address. Images of these notifications are available to participants and client representatives from our website. In response to a secondary qualifying event (e.g., in a divorce situation), we will set up the dependent within the system as a separate qualified beneficiary and issue separate notifications and communications to their address.
121	By what methods do you notify dependents who are on continuation coverage that reach the limiting age for the plan?	121	Dependent status is determined by the group health plan document. An exceptions report indicating dependents reaching the limiting status is available to the client on demand from our website. Clients can initiate a secondary qualifying event notification online for the dependent should the client determine they no longer meet the participation standards.
122	Do you provide HIPAA certificates of creditable coverage?	122	Please select
123	How do you report COBRA coverage elections, terminations and changes back to the City?	123	No. HIPAA Certificates of Creditable Coverage are no longer required effective December 31, 2014 based upon Department of Health and Human Services and the Centers for Medicare & Medicaid Services final regulations that amend the Health Insurance Portability and Accountability Act (HIPAA) portability rules. HealthEquity does not provide HIPAA certificates as a standard service.
124	How do you report COBRA coverage elections, terminations and changes to carriers/vendors?	124	We provide eligibility updates to carriers on behalf of the client. We communicate eligibility and activity on a weekly basis and send a full file at month end. Reports are provided in standard formats of FTP, secure email, fax, or electronic file feed based upon the carrier's requirements and preferences. Carrier-specific electronic file formats are available for clients with a large volume of participants per carrier. Carrier eligibility reporting services are included in our standard fees.

125	Provide a brief overview of your online reporting capabilities.	125	We offer a robust suite of COBRA reports that exceed the needs of most clients. Options include on-demand reporting capabilities from the client portal as well as scheduled reporting functionality On-demand reporting provides clients access to real-time reporting data with multiple search parameters, such as division, date, and activity type to return the most relevant data. These comprehensive reporting options provide clients the ability to immediately address virtually any form of audit request. Scheduled reporting is provided to the client on a pre-determined basis. We will work with you during implementation to auto-schedule eligibility and other necessary reports. These reports are sent in a standard format via fax or email. Reports sent via email are protected by encryption. Electronic reports can be provided in text, PDF, Comma Separated Value (CSV), or Tab Separated Value (TSV) formats. Reports sent in CSV or TSV formats can be imported into Excel for further analysis and manipulation by the client. Employers can choose a distribution schedule for these auto-schedule reports (available daily, weekly, bi-weekly, or monthly). Common scheduled reports include eligibility reports, returned mail reports, and open enrollment processing. Examples of COBRA reports include: Eligibility Reporting This series of reports allows clients to view participants in the waiting period, continuants, and cancelled participants. □ COBRA Continuation Pending Report: Employees who have had a qualifying event, have not elected to continue COBRA, and are in the 60-day election period. □ Status of COBRA Continuants: Participants currently on COBRA. Details include date of qualifying event, reason, eligibility end date, etc. □ Cancelled Eligible Employees and Continuants: Participants for whom COBRA coverage has expired, that have never elected, that have requested cancellation, or that have cancelled for non-payment of premium. Participant records remain on this report for 120 days. □ Future Qualifying Events: Qualifying events that have been processed with a qualifying event date, which will occur in the future. □ Covered Participants by Plan: Lists each plan and the number and names of participants covered by plan. □ All Covered Employees by Plan: Lists each plan and names of employees covered by plan. □ COBRA Continuants as of 12/31 by Plan/COBRA Continuants as of 12/31 by Participant: Continuants by each COBRA-eligible benefit plan, as of the end of the most recent calendar year. The report can be sorted alphabetically, by social security number, etc., as of the end of the most recent calendar year. □ Participants in COBRA Election Period with Effective Dates Prior to 12/31 by Participant: Participants in their election period (by
126	Can you provide COBRA administration services in half months? For example, if the employer pays for 2 1/2 months of COBRA for a participant, can you charge the participant for the remaining 1/2 of the month?	126	Yes
127	Does your system have the ability to default members into COBRA elections?	127	Yes
128	Will you mail annual open enrollment materials to participants?	128	Yes

128a	What are the charges?	128a	We offer multiple open enrollment service options to assist clients in updating their COBRA populations of new enrollment offerings. Service options available to clients include: □ Partial Service ($8.00 per packet): This level of service includes updating rates and plans; producing and mailing rate change notices; notifying carriers of new participant enrollments, terminations and/or other changes and providing toll-free participant service assistance. An annual setup fee of $150 applies. □ Standard Service ($15.00 per packet): This level of service includes updating rates and plans; producing open enrollment letters and forms notifying participants of what benefits are available to them along with the applicable rates; processing all returned open enrollment forms; notifying carriers of new enrollments, terminations, and other changes; and providing toll-free participant service assistance. We will produce and mail participant open enrollment notice and election form packages, up to seven sheets of paper (double sided). An annual setup fee of $150 applies. □ Custom Service ($22.00 per packet): This level of service includes updating rates and plans; producing open enrollment letters and forms notifying participants of what benefits are available to them along with the applicable rates; processing all returned open enrollment forms; notifying carriers of new enrollments, terminations, and other changes; and providing toll-free participant service assistance. We will produce and mail participant open enrollment notice and election form packages, up to 30 sheets of paper (double sided). Special handling for division-based communications and/or custom inserts. An annual setup fee of $150 applies.
129	Will you provide enrollment forms?	129	Yes
129a	What are the charges?	129a	Electronic copies are included.
130	Please indicate which Web-based functions will be available to the employer?	130	Our employer web portal provides clients real-time access to COBRA and Direct Bill activity information 24 hours per day. The website provides clients the ability to: □ Review member records □ Review and update demographics □ View PDF images of notices issued □ Access real-time reporting including on-demand and scheduled reports □ Update eligibility □ Review processed life and COBRA qualifying events □ Review mailed and electronic payments □ View eligibility reporting to carriers □ View complete audit trails for selected employees, divisions, or types of events □ View member support requests □ Submit broker/employer web cases to customer service
131	Please indicate which Web-based functions will be available to the participants?	131	The COBRA participant website provides self-service opportunities for participants and offers real-time access to coverage and account information. Online services available to COBRA participants include the ability to: □ Elect COBRA □ View and print invoices and other notices □ Pay premiums (one-time electronic check) □ Establish recurring, electronic payments □ Edit phone number and e-mail address □ Review payment history and status □ Review elected coverage □ Create a secure customer support request □ Access participant message center to track status of support requests and review resolution □ Online election of open enrollment (with optional open enrollment services)
132	Describe your procedures for tracking coverage start and stop dates.	132	Upon notification of a qualifying event from the client or their vendor, HealthEquity will issue a COBRA election/qualifying event notification. This notice provides information about COBRA rights, deadlines, duration of coverage(s), alternatives to COBRA, and payment responsibilities. The notice also details the qualifying event reason and instructions about electing and paying for COBRA coverage, including the effective date and deadlines
133	When are continuation coverage termination notices sent?	133	Within 60 days prior to the coverage end date, we will mail a reminder notice that explains the expiration of COBRA coverage eligibility is approaching. At the client's request, this notice can include information regarding conversion options and contact information (if available).

134	What options are available for billings/premium invoices to participants?	134	We issue monthly invoices to participants for COBRA premium payments. Monthly invoicing allows us to proactively notify COBRA participants in the event of payment shortages or changes in premium rates. For instance, in the event of a rate change, a COBRA participant that relies on the payment due in the coupon book could inadvertently make a partial payment. This situation could place the participant in an actionable position or allow them to successfully petition for reinstatement of COBRA coverage. In addition, monthly invoicing provides more opportunities to identify if other plan coverage has been obtained. The invoice includes a remittance slip to be returned with the participant's premium as verification of continued eligibility for COBRA coverage.
135	What is your policy regarding incorrect premium payments?	135	If the participant's payment is less than or equal to the lesser of (a) $50, or (b)10 percent of the required COBRA premium, the payment is accepted and applied to the participant's account. An insignificant payment notification is sent to the participant to collect the premium shortage. The premium difference must be submitted by the participant prior to the expiration of the grace period or 30 days from the date the notification is sent, whichever is later. Participants failing to submit the past due portion of the premiums within the required period are cancelled. If a participant submits more than the COBRA premium required by the plan, the excess payment is credited to the participant's account. The credited amount will be reflected on the next month's invoice. Any overpayment received beyond the COBRA-eligible period will generate a refund due back to the continuant. HealthEquity processes refunds weekly with checks issued twice a week. Refunds are issued by check following a waiting period to allow checks and ACH payments to fully clear the bank. In total, the turnaround time is typically 30 days.
136	Do you send late payment warnings to COBRA participants?	136	We provide monthly invoicing that details past due and grace period information. Additionally, this information is reflected in real time on our COBRA website and IVR system. If an additional notice advising of a late payment is requested, a grace payment reminder can be mailed for an additional fee.
137	Do you send monthly billing notices/premium statements to COBRA participants?	137	Yes
138	Do you communicate directly with COBRA beneficiaries regarding billing and/or eligibility issues?	138	Yes
139	Does your company remit premium to the carriers/vendors and perform the premium reconciliations?	139	We can remit premiums to carriers as an optional service. With this service, HealthEquity remits collected premiums to carriers monthly. Full or partial (e.g., ASO fees, selected plans only) carrier remittance services are available. Our implementation team will review the client's business requirements and needs to determine if this service model is a best practice based upon their specific situation. Additional fees apply.
140	Do you return the incorrect premium payments to the COBRA beneficiary?	140	If a participant submits more than the COBRA premium required by the plan, the excess payment is credited to the participant's account. The credited amount will be reflected on the next month's invoice. Any overpayment received beyond the COBRA-eligible period will generate a refund due back to the continuant. HealthEquity processes refunds weekly with checks issued twice a week. Refunds are issued by check following a waiting period to allow checks and ACH payments to fully clear the bank. In total, the turnaround time is typically 30 days.
141	What is your process when correspondence, notices, premium statements are not deliverable? Please explain separately related to initial notifications, qualifying event notices, termination of coverage notices, premium statements, non-payment of premium notices.	141	Our return mail process tracks all returned mail pieces and notifies the client by website reporting and/or email. Clients are encouraged to review these reports and verify that the addresses used on these mailings represent the last known address as per COBRA requirements. From the return mail report, the client has the option to have us resend the requested notifications for participants who are still active. Invoices are mailed monthly and reflect any past due premiums within the client-specified grace period. As an option, clients can choose to have a past due notice issued via mail for an additional fee. HealthEquity offers a variety of methods to ensure participants understand important account information, such as premium due dates. Participants can also evaluate premium due dates by reviewing imaged notices or real-time account information from the participant website. Premium due dates are available on the toll-free interactive voice response (IVR) as well. A qualified beneficiary has 45 days after the date on which they elected COBRA to make an initial payment. After the initial payment, COBRA premiums are subject to a 30-day grace period after the due date. Configurable client options are available if the client wishes to offer more lenient grace periods. Premium payments not received within the grace period result in coverage cancellation.

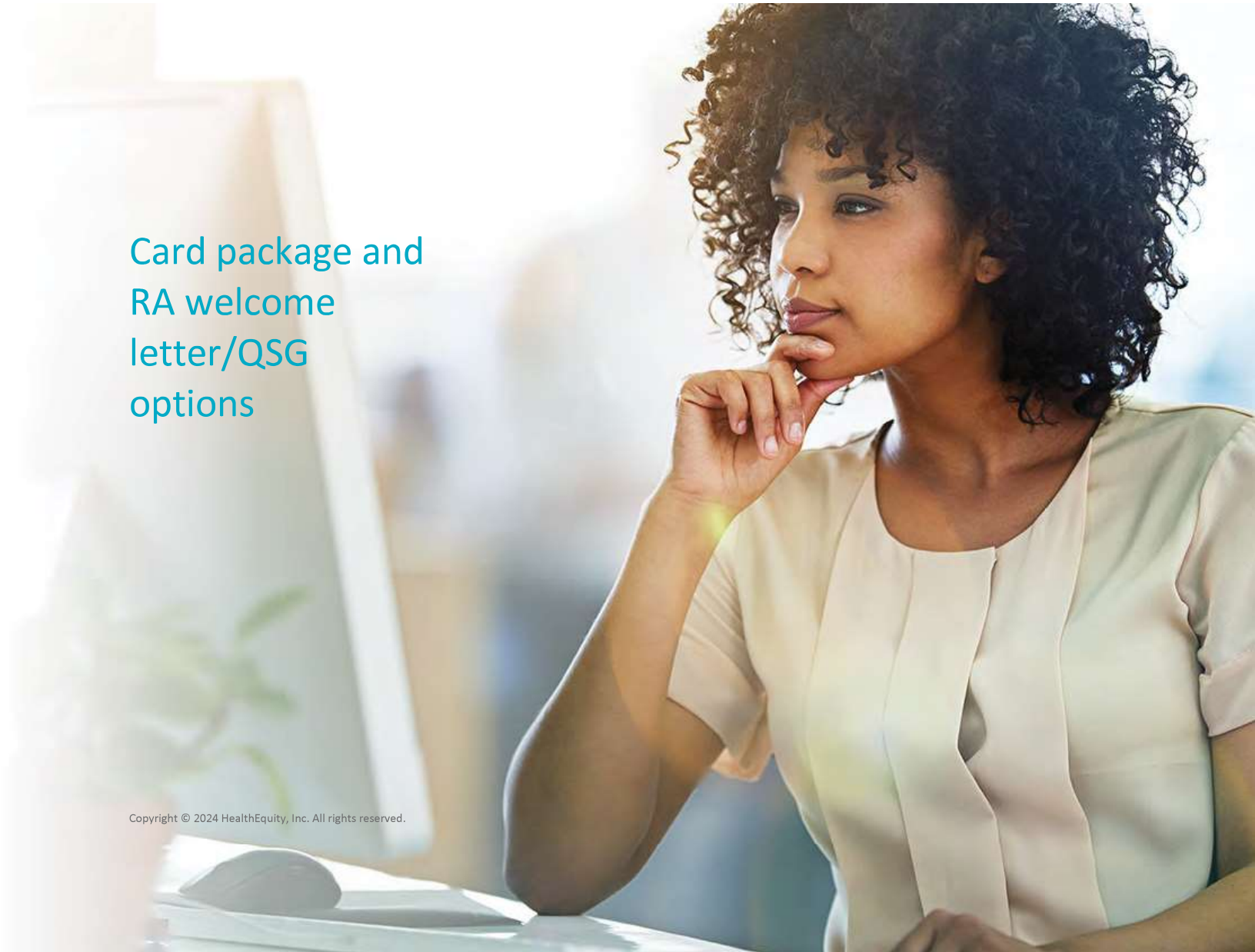
142	Does your company conduct COBRA satisfaction surveys? If so, describe method and frequency?	142	We utilize a post-call participant survey for COBRA participants. This survey focuses on first call resolution, participant effort, call handling, and overall participant satisfaction.
143	Will you provide performance guarantees for COBRA administration?	143	Yes. Please see **Attachment - Performance Guarantees**.

Section 16 - Flexible Spending Accounts (FSAs)

			Vendor Response
144	What office location will handle FSA customer service and claims administration?	144	HealthEquity is headquartered in Draper, Utah and maintains an operations center in Irving, Texas. Additionally, we maintain a remote workforce nationwide with remote employee concentrations in the Salt Lake City, Utah; San Francisco, California; Louisville, Kentucky; Minneapolis/St. Paul, Minnesota; Dallas, Texas; Seattle, Washington; and Phoenix, Arizona markets.
145	Describe your process, including frequency, for bank account reconciliation.	145	HealthEquity reviews and returns funds to clients 45 days after run out. Funds are returned via automated clearing house (ACH), if on file, or check. An email is sent to the client notifying them that the review was completed and directing them to the employer portal for additional information. The client is notified of the amount to be returned, less any outstanding fees, along with the method of the return. Funds are returned to the employer between 45 and 60 days after runout.
146	Can you process health care FSA contributions from terminated employees on COBRA?	146	Yes
147	Describe how you will work with the City to administer COBRA for the FSA products.	147	Upon receiving a qualifying event to our COBRA system, our team will work with the client to determine if an individual is eligible to continue their Health FSA under COBRA. If the Health FSA is overspent (negative balance), COBRA is not offered. Based upon our experience, the volume of participants who elect to continue FSA under COBRA is very small. The paid-through date must be taken into consideration to continue coverage. Many clients work directly with our client service team or manually update the participant's election via our employer website to extend FSA coverage appropriately for those who have elected and paid for continuation of their FSA plan under COBRA.
148	How do you handle forfeited funds?	148	Clients can calculate their plan forfeitures using account activity reporting. The report can be used to reconcile payroll deduction records against card spend, claims payments, and authorized payments after the plan year and run out are complete. Additionally, our Contributions and Payments report provides clients with valuable information regarding settled and issued payments during the plan year. We conduct an end-of-plan-year reconciliation 90 days after the plan's last claims processing date. We reconcile weekly FSA debit card and claims payments against replenishment and initial funding amounts received. The balance is returned to the client, less any outstanding fee invoices.
149	Is the option available to provide a daily limit?	149	Yes
150	Please provide an expected turnaround time that describes how long it will take for participants to receive reimbursements for Dependent Care FSA expenses after they submit valid documentation.	150	HealthEquity processes claims and issues reimbursements daily. We approve claims within two business days of receipt and issue reimbursements within three to five days.
151	Please outline the available DCFSA reimbursement options (e.g. paper check, direct deposit).	151	Dependent care FSA reimbursement option include: ☐ Reimbursement issued via preferred method of direct deposit or mailed check ☐ Direct pay to providers where funds are paid directly from the member account to their designated providers ☐ Automatic payments from single claim form submitted at the beginning of the plan year

152	What FSA features/advantages does your organization provide that make you stand out?	152	Our commitment to our members and clients means connecting them with the accessible and flexible digital capabilities that customers expect in today's connected world. For clients, our customizable programs and platforms integrate easily into existing client branding, messaging, and digital infrastructures. We adhere to the strictest security levels of information protection and deliver actionable data, unmatched insights, and total transparency through our reporting capabilities. For new clients and members, we offer seamless integration into existing programs and platforms. Our customizable, mobile-first approach to digital helps members to make the most of smartphone technology with: • Access to reimbursement account claims and balances on-demand • Full claim processing via smartphones including uploading images of receipts for submission • Options to pay providers directly, reimburse themselves for out-of-pocket expenses, or use the claim as a receipt for outstanding FSA or HRA card transactions • Get tax statements, invest, contribute, check claims, and order new cards • Connect live member service teams via phone or online chat To ensure we consistently deliver world-class service for all members, we use behavioral analytics software to actively measure the quality of our member service interactions including tone, inflection, pace, and word choice. It's the key to maintaining our reputation for excellent service.
153	Does your company conduct FSA satisfaction surveys? If so, describe method and frequency?	153	We credit our world-class level of service as one of the reasons why HealthEquity has been so successful as an organization. To ensure remarkable service, we actively gather feedback to gauge client satisfaction. We conduct account calls and service reviews with each client on a regular basis as part of our drive to constantly improve each client relationship. Twice a year, clients receive a survey on their experience with management, customer service, claims, and product satisfaction and are encouraged to include comments. We also use our Customer Satisfaction (CSAT) ratings and Net Promoter Scores (NPS) to determine overall client satisfaction. While our scores consistently rank among the top performers in the industry, we've recently launched an enterprise-wide initiative focused on achieving and improving our client NPS and CSAT ratings. HealthEquity gauges member satisfaction through feedback obtained via NPS and CSAT surveys. NPS measurements are managed internally using transactional surveys. Surveys are either triggered after a member contacts us (via phone or written inquiry) or upon completing a transaction online. We also calculate a member CSAT to represent the overall percentage of customers who are very satisfied with our interactions. Our scores are consistent with top service industries nationwide.
154	Will you provide performance guarantees for FSA administration?	154	Yes. Please see **Attachment - Performance Guarantees**.

Card Package and RA Welcome Letter/QSG Guide



Card package and RA welcome letter/QSG options

HSA, FSA/HRA AND COMMUTER CARD PACKAGES AND LETTERS

STANDARD

HealthEquity's card packages/letters are designed to help employees understand the employer benefit offering and healthcare account.

- Standard HealthEquity card
- Standard HealthEquity branded card carrier with standard content
- Standard HealthEquity legal inserts
- Standard RA Welcome Letter/QSG
- Available for all benefit eligible tiers.

BRANDED

- Employer and HealthEquity cobranded card
- Employer and HealthEquity cobranded card carrier with standard content
- Standard HealthEquity legal inserts
- Cobranded RA Welcome Letter/QSG
- Available for clients with 2,000+ benefit eligible.

MESSAGING

- Employer and HealthEquity cobranded card
- Employer and HealthEquity cobranded card carrier with standard content
- Custom message area on card carrier
- Standard HealthEquity legal inserts
- Cobranded RA Welcome Letter/QSG
- Available for clients with 5,000+ benefit eligible.

No customizations are available on legal content. All content is subject to HealthEquity approval. **Branded customizations are available to groups with 2,000+ benefit eligible. Messaging customizations are available to groups with 5,000+ benefit eligible.**

TABLE OF CONTENTS

LEAD TIMES

Card Package/RA Welcome Letter/QSG implementation

To ensure your members receive the card package materials and RA Welcome Letters/QSGs you are implementing, please plan for the following lead times.

Package type	Lead times[1]
STANDARD CARD PACKAGE	15 DAYS
BRANDED CARD PACKAGE	90 DAYS
MESSAGING CARD PACKAGE	90 DAYS
RA WELCOME LETTERS	60 DAYS
QUICK START GUIDE (QSG)	60 DAYS

[1]**Lead times are number of days prior to receiving first enrollment file.**

HealthEquity reserves the right to change collateral at will and in accordance with any regulatory requirements.

STANDARD

Standard HealthEquity card

Standard HealthEquity branded card carrier with standard content

Standard HealthEquity legal inserts

Standard RA Welcome Letter/QSG

No customizations are available on legal content. All content is subject to HealthEquity approval.

STANDARD CARD PACKAGE OVERVIEW

The HealthEquity standard card package is sent first class separately from the RA Welcome Letter \Quick Start Guide (QSG), as a single mailing to new accounts through the US Postal Service and includes:

- HealthEquity Visa Card[1] (with 5 year expiration)
- Card carrier
- Card activation sticker
- Applicable legal documents
- Envelope

Note: Commuter-Only Clients will receive the Blue Commuter Card. Clients with multiple accounts (eg. Commuter + HSA) will receive the purple standard card.


«RETURN ADDRESS DATA1»
«RETURN ADDRESS DATA2»
«RETURN ADDRESS DATA3»

HealthEquity

«MAILINGADDRESSDATA1»
«MAILINGADDRESSDATA2»
«MAILINGADDRESSDATA3»
«MAILING ADDRESSDATA4»

Pay with your powerful HealthEquity® Visa® Card

Ready to pay?
- Select 'credit' before you swipe.
- Card readers may prompt you for a PIN when using your card. If this happens, simply run your card as credit instead.
- Use your card to pay for eligible expenses.
- Visit your member portal for balance updates, account activity, and more.

Manage your account online
- Go to the website
- Click on 'LOG IN/REGISTER'
- Complete the account setup
- Already have an account? Enter your existing username and password

Scan to discover how to get more from your benefits
learn.HealthEquity.com

866.346.5800
my.HealthEquity.com

Questions? We're here for you 24/7

[1]HealthEquity Visa Card is issued by The Bancorp Bank N.A., pursuant to a license from Visa U.S.A. Inc. The Bancorp Bank N.A.; Member FDIC.

STANDARD

STANDARD RA WELCOME LETTERS OVERVIEW

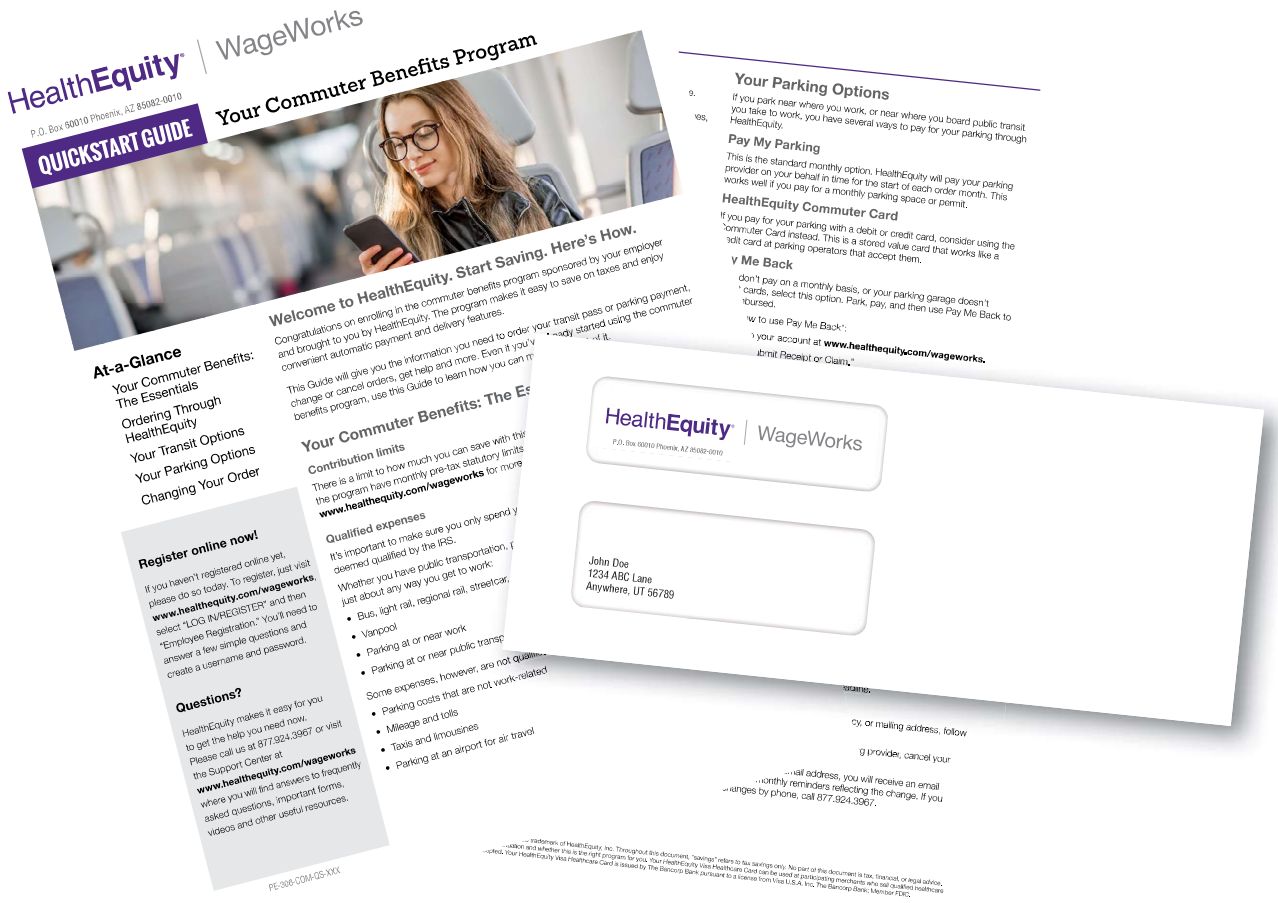
HealthEquity RA welcome letters are sent first class through the US Postal Service as a single mailing upon initial enrollment and annual plan renewals. It provides information related to the plan(s) the member has enrolled in, such as account type and election amounts. The welcome letters include:

- FSA/HRA welcome letter
- FSA/HRA insert specific to account type(s)
- Envelope
- The URL and phone number printed on the front page are variable fields that are populated with your plan's dedicated URL and phone number.
- Plan type, annual election, date to submit and incur expenses, rollover and eligible expenses fields within the table are populated with specific data for each member.

STANDARD

STANDARD COMMUTER or RA QUICK START GUIDE (QSG) OVERVIEW

HealthEquity Commuter or RA QSGs are sent first class through the US Postal Service as a single mailing when we initially populate the account type and election amounts. The Commuter QSG is a 2-page document that includes information on how the member can get the most benefit out of their account.



BRANDED

Employer and HealthEquity cobranded debit card (Employer logo printed on card)

Employer and HealthEquity cobranded card carrier with standard content

Standard HealthEquity legal inserts

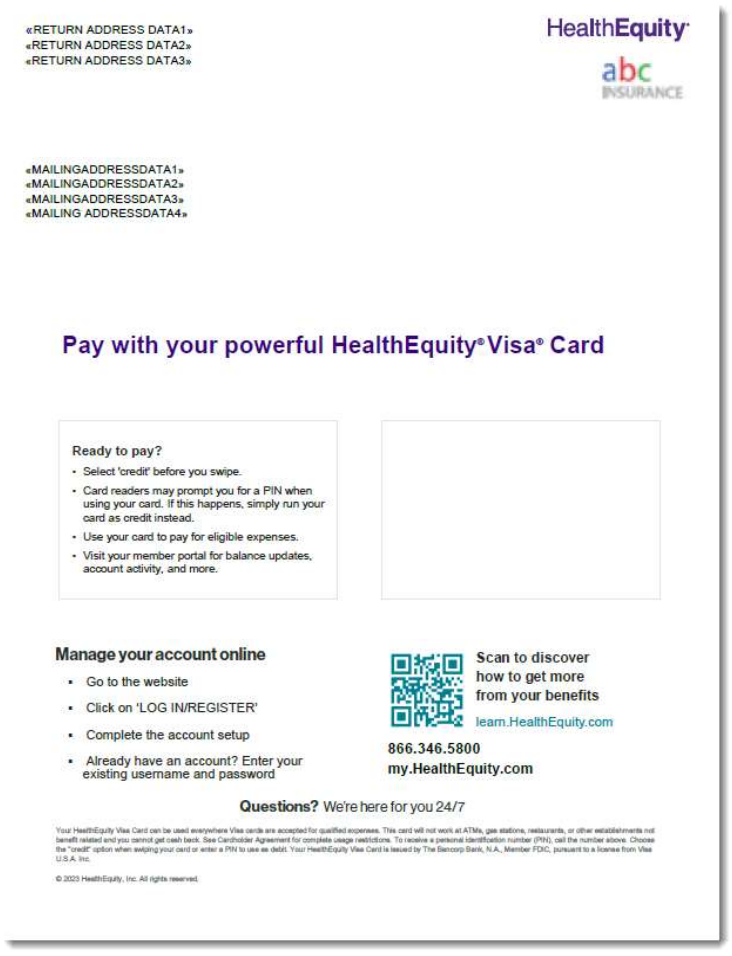
Cobranded RA Welcome Letter/QSG

No customizations are available on legal content. All content is subject to HealthEquity approval. **Branded customizations are available to groups with 2,000+ benefit eligible.**

COBRANDED CARD PACKAGE OVERVIEW

- Your full color logo can be added to the HealthEquity branded card. (Logo should be in .eps or .ai format)
- Your full color logo can be added to the HealthEquity card carrier.
- Member Services phone number and URL are printed on the back of the card.

Note: All cobranded package designs must be reviewed and approved by The Bancorp Bank and Visa. The required due diligence form will be provided to you separately. **Commuter-Only Clients will receive the Blue Commuter Card, Clients with multiple accounts (eg. Commuter + FSA) will receive the white cobrandable card.**



COBRAND

[1]HealthEquity Visa Healthcare Card is issued by The Bancorp Bank, N.A., pursuant to a license from Visa U.S.A. Inc. The Bancorp Bank N.A.; Member FDIC.

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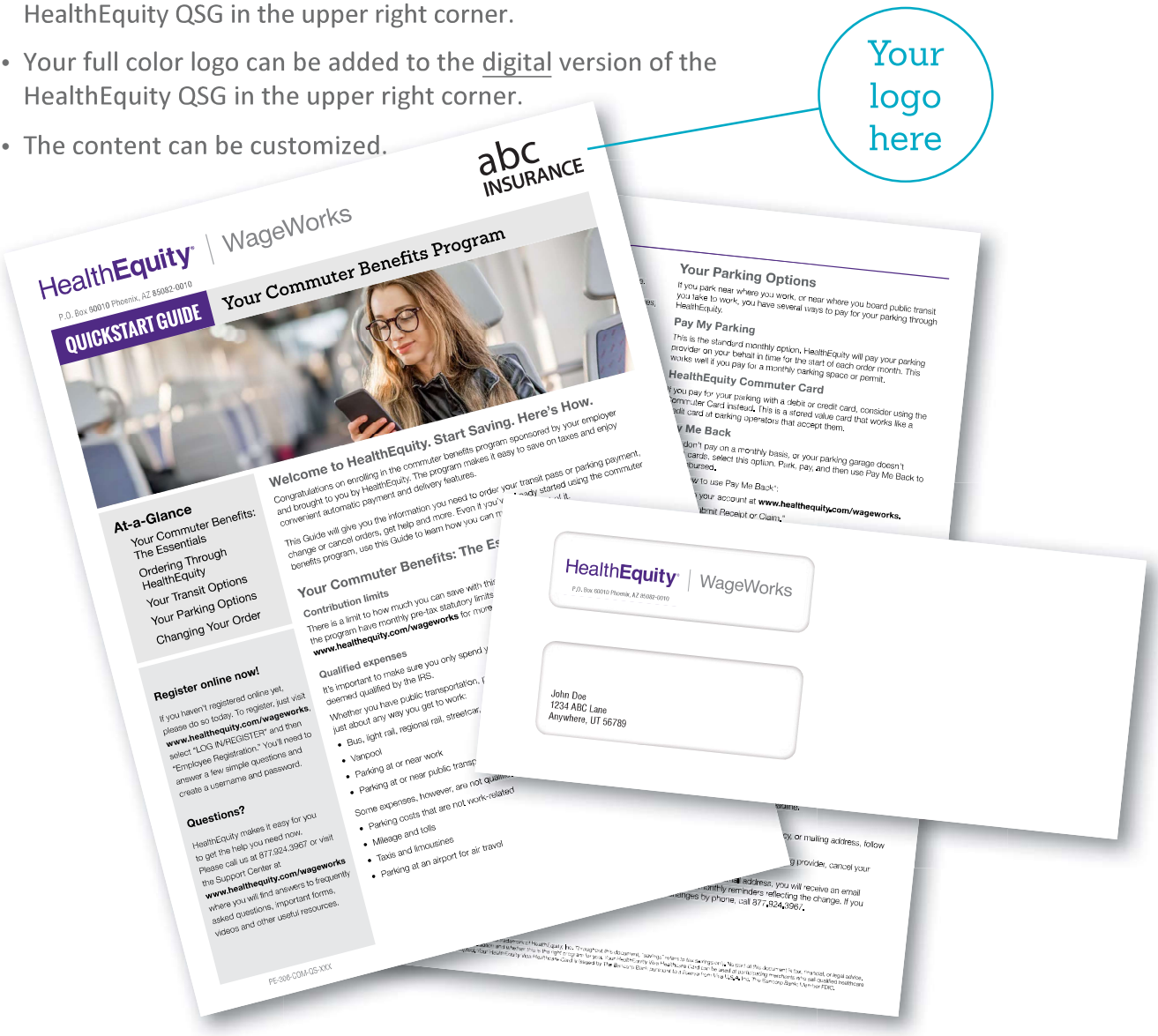
- FSA/HRA insert specific to account type(s)
- Envelope
- The URL and phone number printed on the front page are variable fields that are populated with your plan's dedicated URL and phone number.
- Plan type, annual election, date to submit and incur expenses, rollover and eligible expenses fields within the table are populated with specific data for each member.

COBRAND

COBRANDED COMMUTER or RA QUICK START GUIDE (QSG) OVERVIEW

The Commuter or RA QSG is a 2-page document that includes information on how the member can get the most benefit out of their account.

- Your logo can be added in black only, to the mailed version of the HealthEquity QSG in the upper right corner.
- Your full color logo can be added to the digital version of the HealthEquity QSG in the upper right corner.
- The content can be customized.



COBRAND

MESSAGING

Employer and HealthEquity cobranded debit card (Employer logo printed on card)

Employer and HealthEquity cobranded card carrier

Custom message area on card carrier

Standard HealthEquity legal inserts

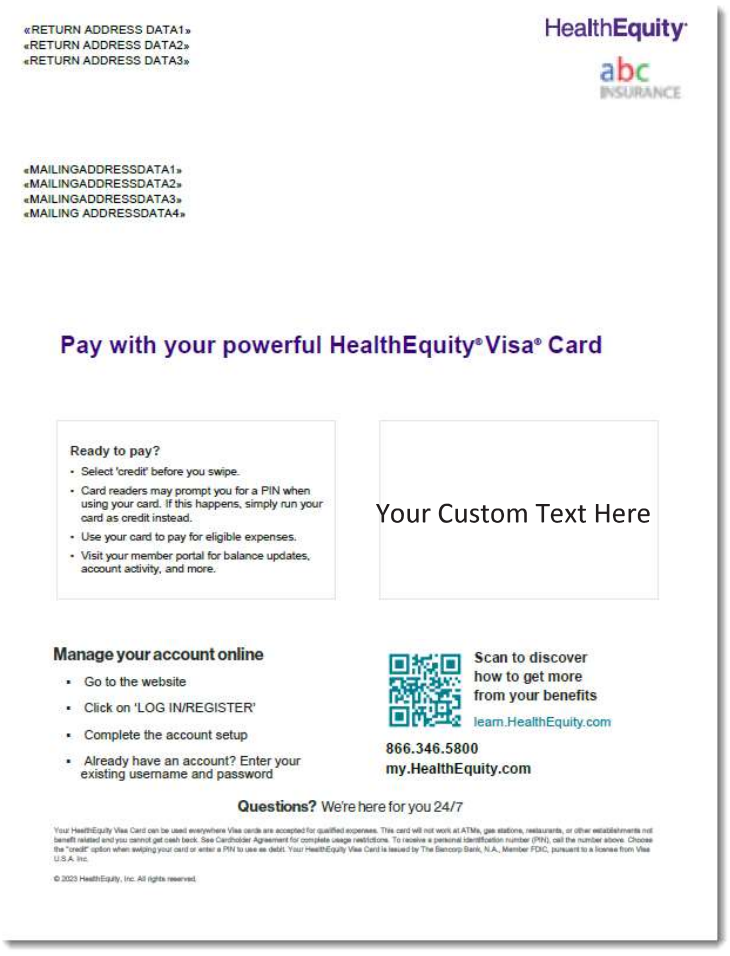
Cobranded RA Welcome Letter/QSG

No customizations are available on legal content. All content is subject to HealthEquity approval. **Messaging customizations are available to groups with 5,000+ benefit eligible.**

MESSAGING CARD PACKAGE OVERVIEW

- Your full color logo can be added to the HealthEquity branded card. (Logo should be in .eps or .ai format)
- Your full color logo can be added to the HealthEquity card carrier.
- Custom messaging text allowed.
- Member Services phone number and URL are printed on the back of the card.

Note: All cobranded package designs must be reviewed and approved by The Bancorp Bank and Visa. The required due diligence application will be provided to you separately. **Commuter-Only Clients will receive the Blue Commuter Card, Clients with multiple accounts (eg. Commuter + FSA) will receive the white cobrandable card.**



MESSAGING

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COBRANDED RA WELCOME LETTERS OVERVIEW

HealthEquity RA welcome letters are sent first class through the US Postal Service as a single mailing upon initial enrollment and annual plan renewals. It provides information related to the plan(s) the member has enrolled in, such as account type and election amounts. The welcome letters include:

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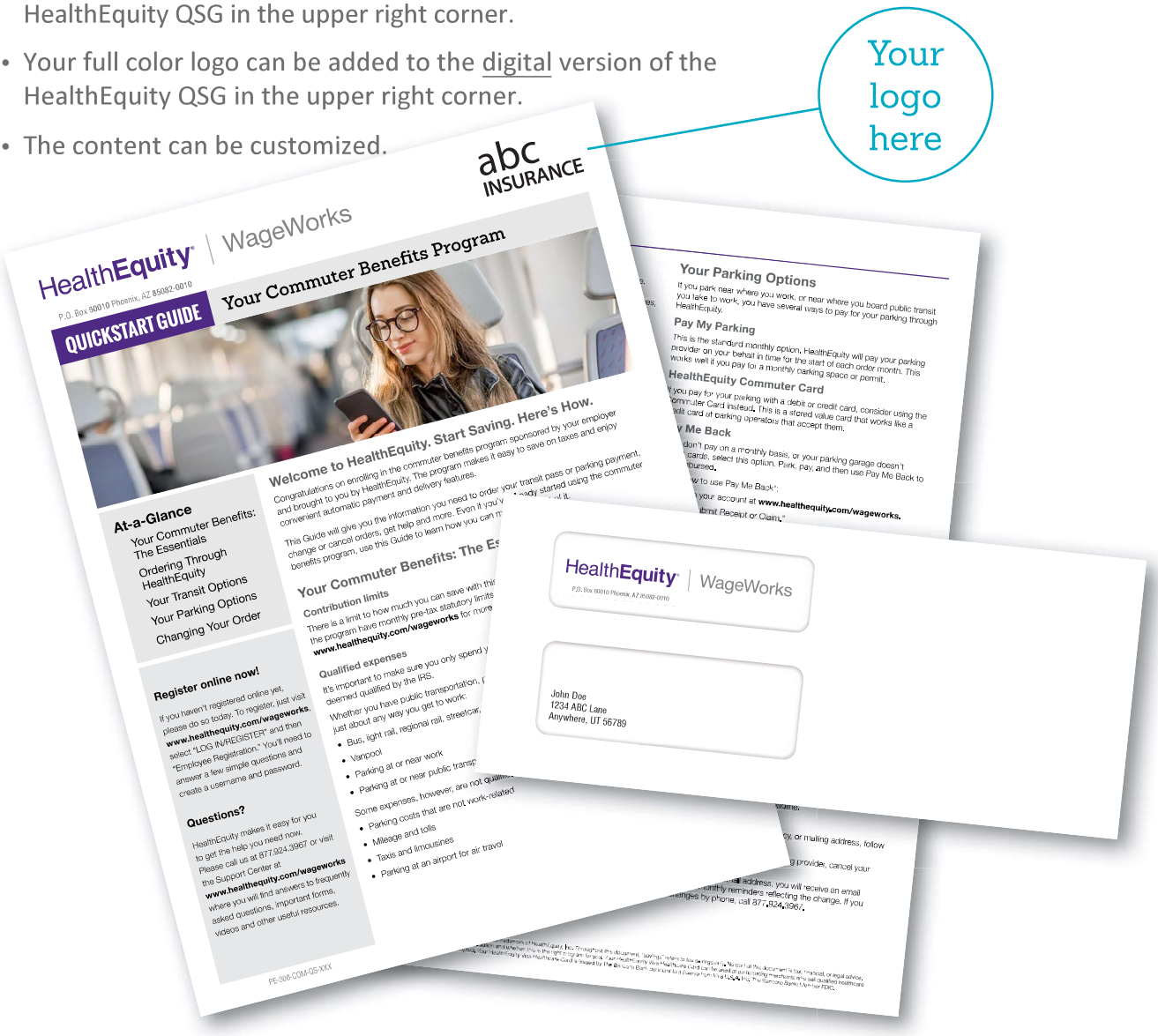
- FSA/HRA insert specific to account type(s)
- Envelope
- The URL and phone number printed on the front page are variable fields that are populated with your plan's dedicated URL and phone number.
- Plan type, annual election, date to submit and incur expenses, rollover and eligible expenses fields within the table are populated with specific data for each member.

COBRANDED COMMUTER QUICK START GUIDE (QSG) OVERVIEW

The Commuter or RA QSG is a 2-page document that includes information on how the member can get the most benefit out of their account.

- Your logo can be added in black only, to the mailed version of the HealthEquity QSG in the upper right corner.
- Your full color logo can be added to the digital version of the HealthEquity QSG in the upper right corner.
- The content can be customized.



MESSAGING

CARD PACKAGE CUSTOMIZATION

STANDARD

HealthEquity's card packages are designed to provide employees convenient access to their benefit offerings and healthcare accounts.

Standard HealthEquity card

Standard HealthEquity branded card carrier with standard content

Standard HealthEquity legal inserts

Included in cost of account administration

BRANDED

Cobranded materials help employers demonstrate the value of their benefit offering backed by HealthEquity's products and services. 2,000+ benefit eligible.

Employer and HealthEquity cobranded debit card (Employer logo printed in one color)

Employer and HealthEquity cobranded card carrier with standard content

Standard HealthEquity legal inserts

$4,000
One-time implementation fee. Available for clients with 2k+ benefit eligible.

MESSAGING

Our Messaging package provides employers the flexibility to target aspects of their service offering that may differ from year to year. 5,000 + benefit eligible.

Employer and HealthEquity cobranded debit card (Employer logo printed in one color)

Employer and HealthEquity cobranded card carrier with standard content

Custom message area on card carrier

Standard HealthEquity legal inserts

$4,000
One-time implementation fee. Available for clients with 5k benefit eligible.

The Branded-level customization tier is available to groups with 2K+ benefit eligible. The Messaging-level customization tier is available to groups with 5k+ benefit eligible. Phone number and URL will be included as designated in the executed contract. Pricing subject to change without notice. No customizations are available on legal content. All content is subject to HealthEquity approval.

HealthEquity®

Contact HealthEquity

For more details and/or assistance, contact your HealthEquity Service Delivery Manager (SDM) or Partner Relationship Manager (PRM).

HealthEquity
Building Health Savings

HealthEquity Eligibility File Specification

A guide for the HealthEquity eligibility file integration process including file specifications and processing standards

Updated May, 2023

HealthEquity Eligibility File Specification

Overview

This document describes the requirements for inbound eligibility data exchange with HealthEquity. The eligibility file provides the means for partners to transmit and manage member demographic and healthcare account enrollment and election information.

The HealthEquity enrollment system is designed to set up and manage healthcare accounts (HSA, HCRA, and HRA). Any enrollment data sent to HealthEquity will create an active account. The sections that follow provide details on how the standard eligibility file sent to HealthEquity should be structured.

File Types

Full Files

Full files are HealthEquity's preferred file type. A full file consists of all active members associated with the population regardless of whether those members have a change associated with their records. HealthEquity can support terminated records being dropped from the file only after the terminated record has been received and processed by HealthEquity.

Change Only Files

The only records included on the file are changes that require HealthEquity's eligibility system to be updated. These files can include additions, changes, and terminations. HealthEquity can support terminated records being dropped from the file only after the terminated record has been received and processed by HealthEquity. If a change only file is sent on a regular basis, HealthEquity requires a full file be sent at least quarterly to ensure data integrity.

Annual Enrollment Files

HealthEquity requires that every record on the eligibility file be sent with a default plan year end date. Due to this, it is necessary to establish new coverage for active members and dependents on an annual basis. HealthEquity can accommodate an off-cycle annual enrollment file to account for new plan year enrollment. Once enrollment for the new plan year has been established, the partner can continue to send files through the current plan year, or resume file delivery once the new plan year has begun. It is important to note that should a termination take place after the new plan year enrollment has been received by HealthEquity, both current and future plan year coverage will need to be terminated.

HealthEquity does not terminate by omission. Dropping a record from a file will not result in a termination of that record. An explicit termination needs to be sent in order for records to be terminated properly.

The early delivery of annual enrollment files will allow debit cards and welcome kits for new enrollees to be mailed in a timely manner. Please work with the production support team to determine when annual enrollment files should be delivered.

File Delivery Details

File Format

HealthEquity prefers a pipe delimited text file and can also accept a tab delimited text file.

File Frequency

HealthEquity can accept eligibility files at any frequency. It is recommended that files are sent at least weekly.

Processing Timing

HealthEquity processes files and records in the order they are received. Files will be processed within two business days of receipt.

File Naming Convention

Our preferred naming convention is: EEF_[SOURCE]_[PARTNER].[YYYYMMDDhhmmss].txt [.pgp|.gpg|.asc]

1. The Source should be the entity submitting the file.
2. The Partner is generally the company name.
3. If Source and Partner are the same, only one of these values is needed. For example, EEF_EmployerX.20230101000000.txt.
4. The YYYYMMDDhhmmss within the file name includes a file date and an optional time stamp which will allow the system to process more than one file in any given day. If a file is sent every day, the time stamp is recommended.
5. The ".pgp" (or ".gpg" or ".asc") extension is required if the file is encrypted. If the file is encrypted, HealthEquity requires that the filename include the .txt before the ".pgp/.gpg/.asc" extension. The encryption key will be provided with the SFTP credentials.

Connectivity

For file transmission information, please refer to the HealthEquity SFTP Manual.

Eligibility File Records and File Layout

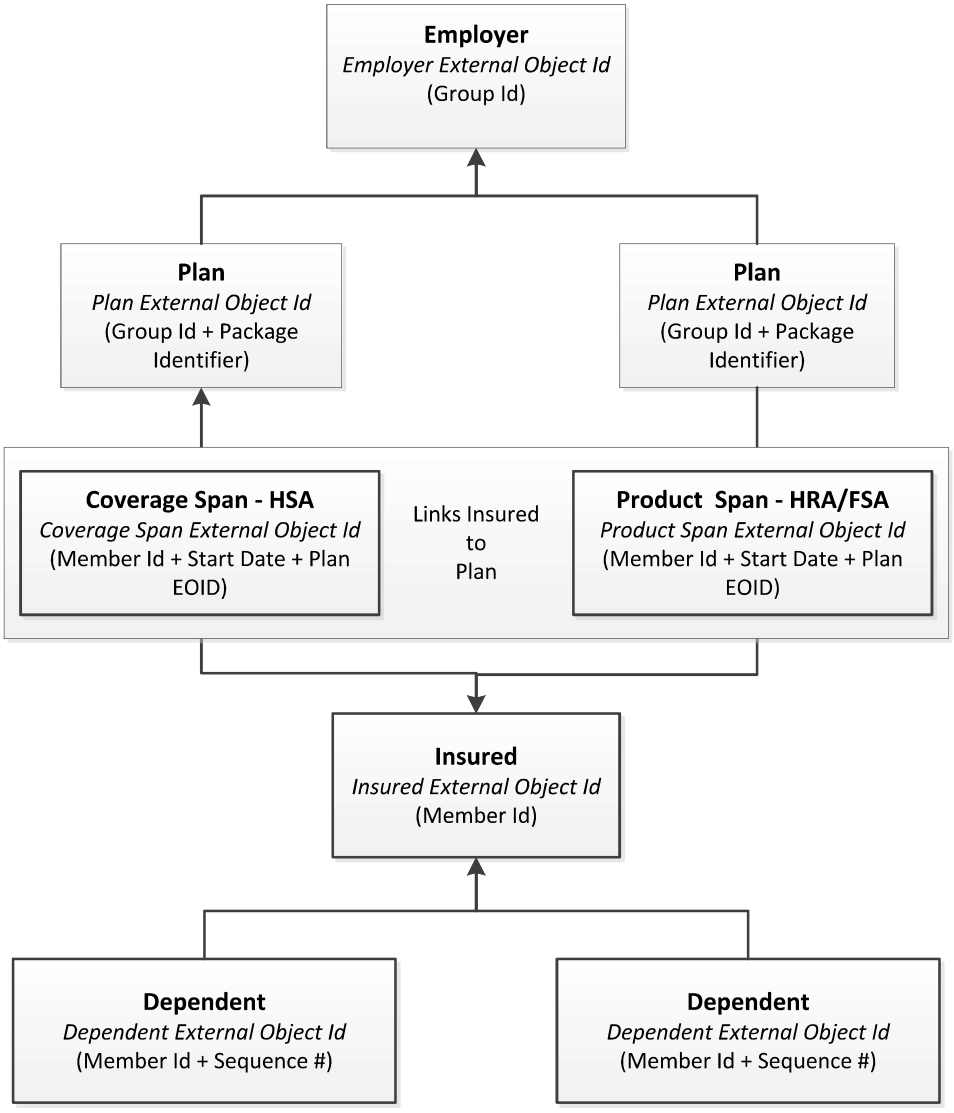
Formatting Requirements

Item	Detail
Alphabetic Fields (A)	Consists only of letters of the alphabet
Alphanumeric Fields (AN)	A combination of alphabetic and numeric characters (*Example 123 Vine Street*).
Currency Fields (C)	Currency fields should not include the dollar sign ($). Values should not be smaller than one cent or two places to the right of the decimal. Please use a period as the fraction separator. Commas and spaces should not be sent in the value (*Example 1200.15*). Do not send $1.200,15; 1200,15; or $1,200.1516. Negatives should not be sent.
Date Fields (D)	Date fields are always in YYYYMMDD format without punctuation. Leading zeroes should be included on months or days that are less than 2 digits long (*Example February 5, 2023 should be 20230205*). Please ensure dates are sent as 8 digit integers. In the HealthEquity system, the termination date is stored as exclusive. For example, if the termination date sent is 12/31/2023, then coverage only goes thru 12/30/2023 and 12/31/21 is excluded. Where only inclusive terminations dates can be sent, approval needs to be obtained through the HealthEquity Implementation team.
Email Address Fields (E)	Email addresses should contain no spaces and have a format that includes a valid domain, an at sign (@), a period, and a valid top domain after the period (*Example i.e. my.heq.email@healthequity.com*). Acceptable characters left of the at sign (@) include periods, dashes, underscores, letters A thru Z, and numbers 0 thru 9. All characters to the right of the at sign (@) need to be part of a valid domain registration.
Numeric Fields (N)	Values for SSN, TIN, and phone numbers should contain dashes (-) as part of their formatting (*Example 123-45-6789*).
String Value Field Length	HealthEquity system limit for any given field is 250 characters.

Field Requirements

Indicator	Detail
R	Required Field. Must be included on the file.
O	Optional Field. Should be included where available.

Record Relationship Diagram



Linking Eligibility File Records

Linking External Object Ids

Each record type described in the Record Relationship Diagram links to the appropriate record via an External Object Id (EOID), which serves as the record's primary key. Each record type should have a unique EOID assigned by the partner to identify the record. Typically EOIDs contain a partner specified Id that will not change over the life of the relationship. EOIDs cannot be changed once established and cannot be reused.

Record Types

The eligibility file layout contains six record types:

- ✓ **Employer:** EOID is determined by the partner
- ✓ **Plan:** EOID is commonly the Employer EOID + Plan Identifier
- ✓ **Insured:** EOID is commonly the Insured's member number, subscriber Id or policy number
- ✓ **Dependent:** EOID is commonly the Insured EOID + Sequence Number or Insured EOID + Dependent's member number
- ✓ **Coverage Spans:** EOID is commonly the Insured EOID + Start Date + Plan EOID
- ✓ **Product Spans:** EOID is commonly the Insured EOID + Start Date + Product Type + Plan EOID

External Object Id Reassignment

If the partner system assigns a new EOID to any record, the following guidelines must be observed:

- ✓ The previous EOID can never be reused.
- ✓ All related records need to reflect the change in EOID assignment. Since the EOID is used to link all of the eligibility records, new records will need to be sent where the EOID change impacts this connection.
- ✓ Records with the previous EOID need to be tied off. For example, coverage spans and product spans with the previous EOID need to be terminated. This will prevent dual or overlapping accounts from being opened for a member.

Any unique EOID sent for any record type will result in a new record. HealthEquity should only receive a record when a full set of accompanying records is available for delivery or already in the HealthEquity system. For example, a plan should never be sent without accompanying employer, insured, coverage span and/or product span, and dependent records.

Updating Records

There are certain fields that can never be updated via file once being received from the partner. These are noted within the record tables that follow. Among these fields are EOIDs, employer Tax Ids, insured SSNs, and start dates.

There are certain fields that can be updated via the employer and member portals. Once changes are made in those environments, a system disconnect is created that will prevent future files from updating the modified fields. This disconnect will be removed if the file is updated to match the modified

information in the portal or if the information in the portal is changed back to match the file. Disconnects of this nature are typical and HealthEquity instructs members and employers to update their information with the file source to ensure continuity of information. Disconnects can also occur when a member has an account with HealthEquity prior to file integration.

Eligibility File Layout

Employer Record

The Employer record establishes a unique employer entity in the HealthEquity system. All records ultimately link up to an Employer record. The employer will have access to the HealthEquity system to make contributions, run reports, and view eligibility.

Record Type	Field Name	Column	Type	Required	Description	Notes
Employer	Record Type	0	A	R	Should always be sent as 'E' *E*	Indicates this is an Employer record.
Employer	EmployerExternalObjectId	1	AN	R	Unique ID for the employer and typically a system generated or hard coded Id **Employer** - Unique Id to be chosen by partner. Can be TIN, if preferred, as long as the Id is consistent **Health Plan** - This is the HP assigned unique identifier for each employer group *12345*	Creates employer portal in HealthEquity system. Cannot be updated.
Employer	EmployerConsortiumId	2	AN	O	Secondary identifier for a sub group *6789*	Used to link sub groups to a master employer group. Allows for the creation of multiple employer portals.
Employer	TaxId	3	N	R	Employer's Tax Id *12-3456789*	Required to load employer. If blank, the employer may require manual intervention to load. Cannot be updated.
Employer	Name	4	AN	R	Employer name, mixed case preferred *ACME Inc.*	Name displayed to the employer and its employees.
Employer	BusinessAddress_Street1	5	AN	R	Employer's street address *123 Acme Ln*	Used for mailing materials, invoices etc.
Employer	BusinessAddress_Street2	6	AN	O	Employer's street address *Suite 3700*	Used for mailing materials, invoices etc.
Employer	BusinessAddress_City	7	A	R	Employer's city *Draper*	Used for mailing materials, invoices etc.
Employer	BusinessAddress_State	8	A	R	Employer's state *UT*	Used for mailing materials, invoices etc.
Employer	BusinessAddress_Zip	9	N	R	Employer's zip *84020*	Used for mailing materials, invoices etc.

Record Type	Field Name	Column	Type	Required	Description	Notes
Employer	Phone	10	N	R	Employer's primary phone number *801-555-1234*	Visible in the employer portal.
Employer	Fax	11	N	O	Employer's fax number *801-555-5678*	Visible in the employer portal.
Employer	Email	12	E	R	Email address for the primary contact *contactus@acmeinc.com*	Employer email is the preferred method to facilitate the HealthEquity Employer Welcome Letter. Visible in the employer portal.
Employer	ContactName	13	A	O	Employer's primary point of contact *John Doe*	Contact should be affiliated with HSA administration. Visible in the employer portal.
Employer	ContactTitle	14	A	O	Title of the primary contact *VP Human Resources*	Visible in the employer portal.

Sample

E|12345|6789|12-3456789|Acme Inc.|123 Acme Ln|Suite 3700|Draper|UT|84020|801-555-1234|801-555-5678|contactus@acmeinc.com|John Doe|VP Human Resources

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Plan Record

Plan records are created to identify to which plan(s) the member should be linked.

Record Type	Field Name	Location	Type	Required	Description	Notes
Plan	RecordType	0	A	R	Should always be sent as 'P' *P*	Indicates this is a Plan record.
Plan	PlanExternalObjectId	1	AN	R	Commonly the EmployerExternalObjectId combined with a plan identifier *12345_HSA5000*	Creates unique identifier for each employer and plan design combination. Cannot be shared across multiple employers. Example might be Employer EOID_HSA+Deductible. Several plans can be sent per product type if needed. Cannot be updated.
Plan	EmployerExternalObjectId	2	AN	R	Unique Id for the Employer *12345*	Links the Plan to the Employer record. Cannot be updated.
Plan	EmployerConsortiumId	3	AN	O	Secondary identifier for a sub group *6789*	Used to link sub groups to a master employer group.
Plan	PlanName	4	AN	R	Visible plan name *Acme CDHP HSA*	Visible in employer portal. Cannot be updated.

Sample

P|12345_HSA5000|12345|6789|Acme CDHP HSA

Discussion

Plan EOIDs

To ensure uniqueness of record creation, one Plan EOID should not be wholly contained within another Plan EOID under a given employer unless plans are meant to be merged. For example, an employer has three HRA plans with EOIDs of 12345_HRA5000, 12345_HRA50001, and XYZ12345_HRA50002XYZ. Because 12345_HRA5000 is wholly contained within the other two EOIDs, it will not be viewed as completely unique and will be merged to one of the other plans in the HealthEquity system.

Cobra Plans

It is HealthEquity's preference that Cobra eligibility be managed through the integrated eligibility file. A separate Cobra plan for each product should be sent on the file in addition to the standard FSA and HRA plans. When a member elects Cobra benefits, they will be termed from the standard plan and enrolled in the Cobra plan. The employer will have access to separate plan reports for Cobra participants and standard plan participants.

If a separate Cobra plan cannot be sent on the integrated eligibility file, Cobra participants can remain enrolled in the standard plan. When a member elects Cobra benefits, there is no change in coverage and the same plan rules will apply. The member and employer experience is seamless. Using this method, Cobra members will not be specifically identifiable to the employer unless the integrated eligibility vendor can update the EmployeeCategory for these members.

If Cobra cannot be administered through the integrated eligibility file, the employer can work directly with HealthEquity to set up a non-integrated Cobra plan that is managed through the Employer Portal. Members who elect Cobra benefits will be termed from the integrated eligibility file and manually enrolled in the non-integrated Cobra plan. The employer will have access to separate plan reports for Cobra participants and standard plan participants.

Due to the nature of the HSA, the same level of Cobra account maintenance is typically not necessary. Any HSA Cobra administration should be managed through the integrated eligibility file.

Insured Record

The Insured record contains basic subscriber demographic information. Each Insured record must be linked to unique active coverage (coverage span or product span).

Record Type	Field Name	Location	Type	Required	Description	Notes
Insured	RecordType	0	A	R	Should always be sent as 'I' *I*	Indicates that this is an Insured record.
Insured	InsuredExternalObjectId	1	AN	R	Unique identifier for insured and commonly the Insured's member Id, subscriber Id, or policy number *A123456*	Links to Dependent and Coverage/Product Span records. This Id will be utilized for SSO and Web Services; therefore, it is important to ensure this Id can be

Record Type	Field Name	Location	Type	Required	Description	Notes
						passed to HealthEquity. Should not be SSN. Cannot be updated.
Insured	Name_LastName	2	A	R	The member's last name *Doe*	Used for Customer Identification Program (CIP) on HSA only.
Insured	Name_FirstName	3	A	R	The member's first name *John*	Used for Customer Identification Program (CIP) on HSA only.
Insured	Name_MiddleName	4	A	O	The member's middle name *E*	
Insured	Name_Suffix	5	A	O	The member's suffix *Sr*	
Insured	Gender	6	A	R	The member's gender *M*	Acceptable values are M, F, and Unknown.
Insured	BirthDate	7	D	R	The member's birthday *19770426*	Used for Customer Identification Program (CIP) on HSA only.
Insured	SSN	8	N	R	The member's social security number *999-99-9998*	Used for Customer Identification Program (CIP) on HSA only. Cannot be updated.
Insured	PhysicalAddress_Street1	9	AN	R	The member's physical address *123 Home Ln*	Can impact CIP verification if not actual street address. Cannot be a P.O. Box. Foreign addresses will not load. Engage your Implementation team to discuss options for members with foreign addresses.
Insured	PhysicalAddress_Street2	10	AN	O	*Apt 14*	
Insured	PhysicalAddress_City	11	A	R	*American Fork*	
Insured	PhysicalAddress_State	12	A	R	*UT*	
Insured	PhysicalAddress_Zip	13	N	R	*84003*	
Insured	MailingAddress_Street1	14	AN	O	The member's mailing address, if different than physical address *P.O. Box 1234*	Used to mail welcome kit, account statements, etc. Foreign addresses will not load. Engage your Implementation team to discuss options for members with foreign addresses.
Insured	MailingAddress_Street2	15	AN	O		
Insured	MailingAddress_City	16	A	O	*American Fork*	
Insured	MailingAddress_State	17	A	O	*UT*	
Insured	MailingAddress_Zip	18	N	O	*84003*	
Insured	PhoneHome	19	N	O	The member's home phone number *801-555-5555*	Strongly recommended for member communication purposes. Could also be used in conjunction with our MFA process to increase account security.
Insured	PhoneWork	20	N	O	The member's work phone number	

Record Type	Field Name	Location	Type	Required	Description	Notes
					801-555-1233	
Insured	Email	21	E	O	The member's email address *johndoe@abc.com*	Strongly recommended this be passed only if emails addresses are active and valid. Could also be used in conjunction with our MFA process to increase account security.

Sample

I|A123456|Doe|John|E|Sr|M|19770426|999-99-9998|123 Home Ln|Apt 14|American Fork|UT|84003|PO Box 1234||American Fork|UT|84003|801-555-5555|801-555-1233|johndoe@abc.com

Dependent Record

The Dependent record contains the basic demographic information for dependents the details of their coverage. Each Dependent record must link to an Insured record. Claim integration is limited if dependent data is not delivered.

Record Type	Field Name	Location	Type	Required	Description	Notes
Dependent	RecordType	0	A	R	Should always be sent as 'D' *D*	Indicates this is a Dependent record.
Dependent	DependentExternalObjectId	1	AN	R	Commonly a combination of the InsuredExternalObjectId and a sequence number or the dependent's member Id *A123456-01*	Unique identifier for each dependent. Links to Insured record. Shouldn't be an SSN - notify HealthEquity representative if SSN is only option. Cannot be updated.
Dependent	InsuredExternalObjectId	2	AN	R	Link to insured *A123456*	Ties the dependent to the insured.
Dependent	Relationship	3	A	R	The dependent's relationship to the insured *Self*	Insured will need a dependent record with relationship of "Self." Card will be sent for Spouse dependent if in the system at time of account loading. Domestic Partners will load as "Other." Acceptable values are Self, Spouse, Child, and Other but data source should send the values they have in their system with a lookup that HealthEquity can use to match to one of the accepted values. If a new, unexpected value

Record Type	Field Name	Location	Type	Required	Description	Notes
						is ever sent it will default to "Other."
Dependent	Name_LastName	4	A	R	Dependent's last name *Doe*	
Dependent	Name_FirstName	5	A	R	Dependent's first name *John*	
Dependent	Name_MiddleName	6	A	O	Dependent's middle name *E*	
Dependent	Name_Suffix	7	A	O	Dependent's suffix *Sr*	
Dependent	Gender	8	A	R	Dependent's gender *M*	Acceptable values are M, F, and Unknown.
Dependent	BirthDate	9	D	R	Dependent's birthday *19770426*	
Dependent	SSN	10	N	O | R	Dependent's social security number *999-99-9998*	This is used for Self and Spouse dependents to access HealthEquity's automated IVR. Please note dependent SSN is required for HRA plans. HealthEquity is a registered reporting entity and the SSN is required for CMS Secondary Payer Reporting.
Dependent	CoverageStartDate	11	D	R	Date the dependent became covered *20230101*	Cannot be updated. This field is only required for HRA plans.
Dependent	CoverageEndDate	12	D	R	Date the dependent is no longer covered *20240101*	End date must be included for each dependent. Cannot term by omission. This field is only required for HRA plans.

Samples

D\|A123456-01\|A123456\|Self\|Doe\|John\|E\|Sr\|M\|19770426\|999-99-9998\|20230101\|20240101
D\|A123456-02\|A123456\|Spouse\|Doe\|Jane\|L\|\|F\|19791026\|999-99-8888\|20230101\|20240101
D\|A123456-03\|A123456\|Child\|Doe\|Fred\|K\|\|M\|20000626\|777-77-8888\|20230101\|20240101

Discussion

Covered Dependents

If HRA enrollment is included in the integrated eligibility file, it's important that the dependent records delivered be limited to those dependents that are covered under the HRA plan. The presence or exclusion of dependents will determine coverage tier and may impact the HRA election amount. It will also impact HRA reimbursements as any dependent would be eligible for reimbursements out of the HRA. Delivering the incorrect dependent population could result in an incorrect HRA election amount or result in the reimbursement of expenses for dependents that are not qualified for reimbursement.

If HRA eligibility is sent on the same file as HSA or FSA eligibility, or if the eligibility vendor doesn't have the ability to limit dependents to those that are covered under the HRA plan, HealthEquity may request the addition of an indicator to specify which dependents are covered and which are not.

It is important that the correct dependent population be delivered to prevent incorrect financial liability to the employer.

Enrollment

Initial enrollment start dates should reflect the start of each dependent's coverage. Start dates should not be sent for the next plan year more than 30 days prior to the plan year start date. HealthEquity sets up a dependent span for each Dependent record. This is generated from the Dependent record and the dependent's coverage start and end dates. Start and end dates are required only when integrating HRA plans.

Changes

It is important to understand how the partner system generates start dates for dependents and what triggers their creation. When a new start date is sent, an explicit termination of the prior start date should also be sent. When a change to the Dependent record occurs, such as a change in relationship or gender, some partner systems generate new start dates reflecting coverage that starts as of that change date. This is acceptable, but it is expected that a termination of the prior start date be sent. Typically these coverage dates will be continuous in that the start date of the new span is the day after the end date of the prior span.

Terminations

It is required that end dates are always populated on Dependent records. These dates should always be within plan year. A subset of the termination is the deletion (termination never effective, also known as a "void of coverage"). A deletion is used for a dependent that was sent over in error. This will remove the dependent from HealthEquity's system. A deletion takes place when the end date is set equal to the start date. Dates are only required on the Dependent record for HRA plans.

Coverage Span Record

The Coverage Span record establishes an HSA and outlines the appropriate coverage period in which an account holder should be enrolled. Each coverage span must link to a unique Plan and Insured record.

Record Type	Field Name	Location	Type	Required	Description	Notes
CoverageSpan	RecordType	0	A	R	Should always be sent as 'C' *C*	Indicates this is a Coverage Span record.
CoverageSpan	CoverageSpanExternalObjectId	1	AN	R	Commonly the InsuredExternalObjectId with the start date appended to it *A123456_20230101_12345_HSA5000*	Unique identifier for each coverage span. Cannot be updated.
CoverageSpan	InsuredExternalObjectId	2	AN	R	Link to insured *A123456*	Ties the coverage to the Insured. Cannot be updated.
CoverageSpan	PlanExternalObjectId	3	AN	R	Links to plan *12345_HSA5000*	Ties the coverage to the plan. Cannot be updated.

Record Type	Field Name	Location	Type	Required	Description	Notes
CoverageSpan	EmployerConsortiumId	4	AN	O	Secondary identifier for a sub group *6789*	Used to link sub groups to a master employer group.
CoverageSpan	EmployeeId	5	AN	O	Allows alternate Id use for contribution uploads *T650*	Displays on employer portal and must be unique. Can be used for employer portal reporting and contribution purposes.
CoverageSpan	EmployeeCategory	6	AN	O	Member department or other category assigned by employer *Non-Union*	Displays on employer portal in department field. This is included on all employer portal reports to allow for more defined reporting.
CoverageSpan	StartDate	7	D	R	The start date of the member's coverage *20230101*	Start date must be included for each coverage span. Cannot be updated.
CoverageSpan	EndDate	8	D	R	Date the member is no longer covered *20240101*	End date must be included for each coverage span. Cannot term by omission.
CoverageSpan	ProductType	9	A	R	An indicator that let's HealthEquity know that the insured has an HSA *HSA*	Acceptable values are HSA for standard welcome kit and enrollment process and HSAIND for the candidate welcome kit and enrollment process.
CoverageSpan	CoverageType	10	A	R	Indicates what type of medical coverage the member has *Family*	Acceptable values are Self and Family.
CoverageSpan	Deductible	11	C	R	In-Network medical deductible for the policy *5000.00*	This should be the deductible for the individual policy holder. If unavailable, send as 0.00

Sample

C|A123456_20230101_12345_HSA5000|A123456|12345_HSA5000|6789|T650|Non-Union|20230101|20240101|HSA|Family|5000.00

Discussion

Enrollment

Initial enrollment start dates should reflect the start of the HealthEquity account coverage. Start dates should not be sent for the next plan year more than 30 days prior to the plan year start date.

Changes

It is important to understand how the partner system generates coverage span EOIDs and what triggers their creation. When a new EOID is sent, an explicit termination of the prior EOID should also be sent. When a change to the Coverage Span record occurs, such as a change in coverage type or employee

category, some partner systems generate new EOIDs reflecting coverage that starts as of that change date. This is acceptable, but it is expected that a termination of the prior coverage span be sent. Typically these coverage spans will be continuous in that the start date of the new coverage span is the day after the end date of the prior coverage span. These coverage updates should also be reflected in Dependent records.

In the HealthEquity system the term date is stored as exclusive (if the term date sent is 12/31/2023, then coverage only goes thru 12/30/2023 and 12/31/21 is excluded). Where only inclusive dates can be sent, approval needs to be obtained through the HealthEquity implementation team. It is important for HealthEquity to understand how dates are being sent to avoid gaps in coverage.

When changes to coverage are made (other than a termination) it is important that the existing Coverage Span record is terminated and a new coverage span be delivered to HealthEquity. This applies specifically to changes to the following fields: Insured EOID, Plan EOID, Start Date, and Coverage Type. The effective date of the change will likely serve as both the end date of the existing coverage span and the start date of the new coverage span.

Terminations

It is required that end dates are always populated on Coverage Span records. These dates should always be within plan year. When coverage span terminations are sent, it is important that the related Dependent records are terminated as well. A subset of the termination is the deletion (termination never effective, also known as a "void of coverage"). A deletion is used for a coverage span that was sent over in error. This will remove the coverage span from HealthEquity's system. A deletion takes place when the end date is set equal to the start date.

Product Span Record

The Product Span record establishes a reimbursement account (HRA, HCRA, LPHCRA, or DCRA) and outlines the appropriate coverage period in which an account holder should be enrolled. Each product span must link to a unique Plan record and an Insured record. Each account type should be sent as a separate line on the file and have a unique product span EOID.

Reimbursement account yearly renewals should be explicit in that annual enrollment must be sent to HealthEquity each year.

Record Type	Field Name	Location	Type	Required	Description	Notes
ProductSpan	RecordType	0	A	R	Should always be sent as 'S' *S*	Indicates this is a Product Span record.
ProductSpan	ProductSpanExternalObjectId	1	AN	R	Unique identifier for each product span *A123456_20230101_HRA_12345_HRA5000*	Unique identifier for each product span. Cannot be updated.
ProductSpan	InsuredExternalObjectId	2	AN	R	Link to insured *A123456*	Links to Insured record.
ProductSpan	PlanExternalObjectId	3	AN	R	Link to plan *12345_HRA5000*	Links to Plan record. Cannot be updated.
ProductSpan	EmployerConsortiumId	4	AN	O	Secondary identifier for a sub group *6789*	Used to link sub groups to a master employer group.

ProductSpan	EmployeeId	5	AN	O	Populates in the employer portal *T650*	Each insured should have one consistent EmployeeId across all spans.
ProductSpan	EmployeeCategory	6	AN	O	Member department or other category assigned by employer *Non-Union*	This is included on all employer portal reports to allow for more defined reporting.
ProductSpan	StartDate	7	D	R	The start date of the member's benefit coverage *20230101*	Must have start date for each product span. Cannot be updated.
ProductSpan	EndDate	8	D	R	Date the member is no longer covered *20240101*	Must have end date for each product span. Cannot term by omission.
ProductSpan	ProductType	9	A	R	Identifies the product type *HCRA*	May be used to assign member to the correct product. Acceptable values are HCRA, LPHCRA, DCRA, and HRA.
ProductSpan	CoverageType	10	A	R	Indicates what type of medical coverage a member has (if applicable) *Family*	Currently informational only, does not drive any functionality. Acceptable values are Self, Family, Parent, and Couple.
ProductSpan	Election	11	C	R	The election amount for the product *1200.00*	Annual election amount for the reimbursement account.
ProductSpan	UpdateElection	12	A	R	Allows or disallows the election to be updated *TRUE*	Acceptable values are TRUE and FALSE.

Samples

S|A123456_20230101_LPHCRA_12345_LPHCRA5000|A123456|12345_LPHCRA5000|6789|T650|Non-Union|20230101|20240101|LPHCRA|Family|1000.00|TRUE

S|A123456_20230101_DCRA_12345_DCRA5000|A123456|12345_DCRA5000|6789|T650|Non-Union|20230101|20240101|DCRA|Family|500.00|TRUE

Discussion

Enrollment

Initial enrollment start dates should reflect the start of the HealthEquity account coverage. Start dates should not be sent for the next plan year more than 30 day prior to plan year start.

Changes

It is important to understand how the partner system generates product span EOIDs and what triggers their creation. When a new EOID is sent an explicit termination of the prior EOID should also be sent. When a change to the Product Span record occurs, such as a change in coverage type or employee category, some partner systems generate new EOIDs reflecting coverage that starts as of that change date. This also applies to changes to the following fields: Insured EOID, Plan EOID, and Start Date. These updates are acceptable, but it is expected that a termination of the prior product span be sent. Typically

these product spans will be continuous in that the start date of the new product span is the day after the end date of the prior product span. These coverage dates should also be reflected in Dependent records.

In the HealthEquity system the term date is stored as exclusive (if the term date sent is 12/31/2023, then coverage only goes thru 12/30/2023 and 12/31/21 is excluded). Where only inclusive dates can be sent, approval needs to be obtained through the HealthEquity implementation team.
It is important for HealthEquity to understand how dates are being sent to avoid gaps in coverage. For example, claims with a date of 12/31/2023 could be denied for no active coverage if dates are not being recognized appropriately.

Terminations

End dates must always be populated on Product Span records. These dates should always be within plan year. When product span terminations are sent it is important that the related Dependent records are terminated as well. A subset of the termination is the deletion (termination never effective, also known as a "void of coverage"). A deletion is used for a product span that was sent over in error. This will remove the product span from HealthEquity's system. A deletion takes place when the end date is set equal to the start date.

Elections

If election is updated and update election is TRUE, the new amount will be applied to the member's account. If election is updated and update election is FALSE, the new amount will not be applied to the member's account. These rules will apply to all elections. When a member terminates, the election should not be zeroed as this will update the member's account. For HRA accounts, the election is typically not delivered on the eligibility file and can be passed as 0.00. In this case, update election should be passed as FALSE.

Trailer Record

The Trailer record gives totals for all of the records sent on the eligibility file. The use of this record is optional.

Record Type	Field Name	Location	Type	Required	Description	Notes
Trailer	RecordType	0	A	R	Enter a T here to let HealthEquity know this is a Trailer record. *T*	Indicates this is a Trailer record.
Trailer	RecordCount	1	N	R	This is the count of all records sent on the file *1200*	Include the Trailer record in the count.
Trailer	FileDate	2	D	R	This is the date the file was created *20230101*	This will typically be the same date as in the file name.

Sample

T|1200|20230101

Discussion

Trailer records are used as an initial point of file processing validation. If the record counts in the file do not match those sent in the trailer record, the file will fail to process.

File Validation

Validation Files

We require several eligibility validation files prior to processing a production file. Once the first validation file is received, it will be mapped by the HealthEquity Engineering Team. A date for a production file can be established once both parties are comfortable the file behaves appropriately in the validation environment. All eligibility changes (additions, changes, and terminations) should be captured on the eligibility file. Our expectation is that validation data will be provided to validate all applicable scenarios.

Validation Expectations

HealthEquity requires a 30 day window from the receipt of the initial validation file to complete its mapping. HealthEquity recommends an additional 30 days for cycle validation. Recommended validation scenarios will be provided by your HealthEquity Implementation Specialist. Failure to validate will likely result in problems with production data, which is much more difficult to resolve than in a validation environment.

As a component of our pre-production validation process, HealthEquity will complete a manual review of the file. This will include checking for duplicate records, ensuring all required data fields are passed, all required data elements are in the correct format, and all data appears to be valid production level data. Our assumption is that our partners wish to test their own file accuracy. HealthEquity does not assume responsibility for validating the quality and accuracy of the data being sent. It is assumed that partners validate data prior to transmitting validation and production files. There may be significant financial impact to the partner or vendor if inaccurate data is sent.

Production File

We require that each partner provide us production counts and a listing of employees by product type for validation. We also require loading the initial production file in our validation environment to validate accuracy prior to loading it in production. Validation and production files should be delivered in the same format.

A production eligibility file must be sent to HealthEquity 2 - 4 weeks prior to the start of the plan year. When plans are effective January 1, files should be sent 4 weeks prior to the effective date. It may take up to 4 business days from receipt for the initial production file to be loaded at HealthEquity. Failure to provide validation and production files within the suggested timeframes may result in members not receiving welcome materials prior to the start of the plan year.

Production Correlation Detail Report

A correlation output report will be provided with an .html or .csv file detailing record level warnings, informational messages or data errors associated with the processed file. The correlation output report will be placed on the HealthEquity Hub and the partner / employer will be provided login credentials and URL path to retrieve the report. A sample correlation report can be provided upon request. Questions about the contents of the report should be directed to your Account Manager.

Validation Scenarios

HealthEquity requires cycle validation to ensure that data changes that occur in production are correctly represented on the file from our partners and mapped by HealthEquity. Some of the validation cases may not be viable based on the type of data that a partner is providing. Please be aware that this document covers both required fields and optional fields.

To assist with validation, HealthEquity will provide the HealthEquity Eligibility Validation Scenarios document. This spreadsheet will be shared between the partner and HealthEquity to track progress and document validation results. Additional information on potential validation scenarios, complete with examples, is available below.

Cycle Zero

Enrollments

This cycle is intended to validate initial enrollments and that the correct connections between records exist. We would expect to see at least a representative subset of the partner population for the scenarios below. The amount of data should be enough for processing subsequent cycles. Deliver complete record sets only. Once received, HealthEquity will verify the following in a validation environment:

- ✓ File is received via test SFTP site and adheres to naming convention
- ✓ Employer record is present on the file and loads
- ✓ Plan record(s) is present and links to the Employer record
- ✓ Insured records are present on the file and load
- ✓ Dependent records are present on the file and link to an Insured record
- ✓ Coverage Span records are present and link to a Plan and an Insured record
- ✓ Product Span records are present and link to a Plan and an Insured record

Cycle One

Terminations

These scenarios are intended to validate the termination of dependents, coverage spans, and product spans. Deliver complete record sets only. For termination validation, HealthEquity may request the following scenarios:

- ✓ Employer
  - Terminate all coverage under a given employer
- ✓ Plan
  - Terminate all coverage under a given plan
- ✓ Dependent
  - Terminate at least one dependent of each dependent type
- ✓ Coverage Span
  - Terminated at least one coverage span under each HSA plan
- ✓ Product Span
  - Terminate at least one product span for each applicable product type

Sample

Existing

D|A123456-01|A123456|Self|Doe|John|E|Sr|M|19770404|999-99-9998|20230101|20240101
D|A123456-02|A123456|Spouse|Doe|Jane|L||F|19791012|999-99-8888|20230101|20240101
D|A123456-03|A123456|Child|Doe|Fred|K||M|20000623|777-77-8888|20230101|20240101
C|A123456_20230101_12345_HSA5000|A123456|12345_HSA5000|6789|T650|Non-Union|20230101|20240101|HSA|Family|3000.00
S|A123456_20230101_12345_LPHCRA5000|A123456|12345_LPHCRA5000|6789|T650|Non-Union|20230101|20240101|LPHCRA|Family|1000.00| TRUE
S|A123456_20230101_12345_DCRA5000|A123456|12345_DCRA5000|6789|T650|Non-Union|20230101|20240101|DCRA|Family|500.00| TRUE

Updated

D|A123456-01|A123456|Self|Doe|John|E|Sr|M|19770404|999-99-9998|20230101|**20230401**
D|A123456-02|A123456|Spouse|Doe|Jane|L||F|19791012|999-99-8888|20230101|**20230401**
D|A123456-03|A123456|Child|Doe|Fred|K||M|20000623|777-77-8888|20230101|**20230401**
C|A123456_20230101_12345_HSA5000|A123456|12345_HSA5000|6789|T650|Non-Union|20230101|**20230401**|HSA|Family|3000.00
S|A123456_20230101_12345_LPHCRA5000|A123456|12345_LPHCRA5000|6789|T650|Non-Union|20230101|**20230401**|LPHCRA|Family|1000.00| TRUE
S|A123456_20230101_12345_DCRA5000|A123456|12345_DCRA5000|6789|T650|Non-Union|20230101|**20230401**|DCRA|Family|500.00| TRUE

Deletions (Termination Never Effective or Void of Coverage)

These scenarios are intended to validate the deletion or void of coverage, usually because it's sent in error. The records impacted by deletions are Dependent records, Coverage Span records and Product Span records. In all cases, the end date on the record should be sent as equal to the start date for a deletion to take place. Deliver complete record sets only. To validate deletions, HealthEquity may request the following scenarios:

- ✓ Employer
  - Delete all coverage under a given employer. This will require that all dependents, coverage spans, and product spans associated to the employer be deleted.
- ✓ Plan
  - Delete all coverage under a given HSA plan. This will require that all dependents and coverage spans associated to the plan be deleted.

- Delete all coverage under a given reimbursement account plan (HCRA, LPHCRA, DCRA, or HRA). This will require that all dependents and product spans associated to the plan be deleted.

✓ Insured & Dependents

- Delete coverage for a specified product and all active dependents under at least one insured. This will require that dependents, coverage spans, and/or product spans be deleted.
- Delete at least one dependent of each dependent type.

Sample

Existing

D|A123456-01|A123456|Self|Doe|John|E|Sr|M|19770404|999-99-9998|20230101|20240101

D|A123456-02|A123456|Spouse|Doe|Jane|||F|19780128|999-99-9997|20230101|20240101

D|A123456-03|A123456|Child|Doe|John||Jr|M|20081227|999-99-9996|20230101|20240101

C|A123456_20230101_12345_HSA5000|A123456|12345_HSA5000|6789|T650|Non-Union|20230101|20240101|HSA|Family|3000.00

S|A123456_20230101_12345_LPHCRA5000|A123456|12345_LPHCRA5000|6789|T650|Non-Union|20230101|20240101|LPHCRA|Family|1000 .00| TRUE

Updated

D|A123456-01|A123456|Self|Doe|John|E|Sr|M|19770404|999-99-9998|20230101|**20230101**

D|A123456-02|A123456|Spouse|Doe|Jane|||F|19780128|999-99-9997|20230101|**20230101**

D|A123456-03|A123456|Child|Doe|John||Jr|M|20081227|999-99-996|20230101|**20230101**

C|A123456_20230101_12345_HSA5000|A123456|12345_HSA5000|6789|T650|Non-Union|20230101|**20230101**|HSA|Family|3000.00

S|A123456_20230101_12345_LPHCRA5000|A123456|12345_LPHCRA5000|6789|T650|Non-Union|20230101|**20230101**|LPHCRA|Family|1000.00| TRUE

Correcting Enrollments

These scenarios are intended to validate correcting enrollments when they are initially sent for the incorrect product or with an incorrect start date. Both a deletion and an addition will be required to correct enrollment. In all cases, the end date on the record should be sent as equal to the start date for a deletion to take place. Deliver complete record sets only. To validate enrollment corrections, HealthEquity may request the following scenarios:

✓ Employer

- Delete all coverage under a given employer for a specified product sent in error. This will require that all coverage spans and/or product spans associated to the employer be deleted.
- Add new enrollment for the correct product. This will require that new coverage and/or product spans be sent for all active members associated to the employer.

✓ Plan

- Delete all coverage under a given plan (HSA, HCRA, LPHCRA, DCRA, and/or HRA). This will require that all coverage spans and/or product spans associated to the plan be deleted.
- Add new enrollment for the correct product. This will require that new coverage and/or product spans be sent for all active members associating them to the correct plan.

✓ Insured

- Delete coverage for at least one insured sent in error. This will require that coverage spans and/or product spans be deleted.
- Add new enrollment for the correct product. This will require that new coverage and/or product spans be sent.

Sample

Existing Insured

C|A123789_20230101_12345_HSA5000|A123789|12345_HSA5000|6789|T650|Non-Union|20230101|20240101|HSA|Family|3000

S|A123456_20230101_12345_HCRA5000|A123456|12345_HCRA5000|6789|T650|Non-Union|20230101|20240101|HCRA|Family|1000.00|TRUE

Updated Insured

C|A123789_20230101_12345_HSA5000|A123789|12345_HSA5000|6789|T650|Non-Union|20230101|**20230101**|HSA|Family|3000.00

S|A123456_20230101_12345_HCRA5000|A123456|12345_HCRA5000|6789|T650|Non-Union|20230101|**20230101**|HCRA|Family|1000.00|TRUE

New Insured

C|A123456_20230101_12345_HSA7000|A123456|**12345_HSA7000**|6789|T650|Non-Union|20230101|20240101|HSA|Family|3000.00

S|A123789_20230101_12345_LPHCRA2000|A123789|**12345_LPHCRA2000**|6789|T650|Non-Union|20230101|20240101|**LPHCRA**|Family|1000.00|TRUE

✓ Coverage Span

- If a coverage span is sent with the incorrect start date, it will need to be deleted and correct coverage will need to be sent. Start dates are not updatable.
- Delete at least one coverage span sent with the incorrect start date.
- Add new HSA coverage with a different start date. This will require that a new coverage span be sent.

Sample

Existing Coverage Span
C|A123456_20230101_12345_HSA5000|A123456|12345_HSA5000|6789|T650|Non-Union|20230101|20240101|HSA|Family|3000.00

Updated Coverage Span
C|A123456_20230101_12345_HSA5000|A123456|12345_HSA5000|6789|T650|Non-Union|20230101|**20230101**|HSA|Family|3000.00

New Coverage Span
C|**A123456_20230301_12345_HSA5000**|A123456|12345_HSA5000|6789|T650|Non-Union|**20230301**|20240101|HSA|Family|3000.00

- ✓ Product Span
  - If a product span is sent with the incorrect start date, it will need to be deleted and correct coverage will need to be sent. Start dates are not updatable.
  - Delete at least one product span sent with the incorrect start date.
  - Add new coverage for the same product (HCRA, LPHCRA, DCRA, or HRA) with a different start date. This will require that a new product span be sent.

Sample

Existing Product Span
S|A654321_20230101_12345_LPHCRA5000|A654321|12345_LPHCRA5000|6789|T650|Non-Union|20230101|20240101|LPHCRA|Family|1000.00|TRUE

Updated Product Span
S|A654321_20230101_12345_LPHCRA5000|A654321|12345_LPHCRA5000|6789|T650|Non-Union|20230101|**20230101**|LPHCRA|Family|1000.00|TRUE

New Product Span
S|**A654321_20230301_12345_LPHCRA5000**|A654321|12345_LPHCRA5000|6789|T650|Non-Union|**20230301**|20240101|LPHCRA|Family|1000.00|TRUE

Additions

These scenarios are intended to add records to the initial enrollments sent in Cycle Zero. Deliver complete record sets only. As part of this validation, HealthEquity will request that you add new records of the following types to the file:

- ✓ Employer
- ✓ Plan
- ✓ Insured
- ✓ Dependent
- ✓ Coverage Span
- ✓ Product Span

Changes

These scenarios are intended to change existing data sent in Cycle Zero. Changes can be within one record or across several records. Deliver complete record sets only. Fields that should be changed within each record are specified below.

- ✓ Employer
  - Updates to the following fields should be validated: Name, Address, Phone, Fax, Email, Contact Name, and Contact Title
- ✓ Insured record
  - Updates to the following fields should be validated: Name, Gender, Birth Date, Address, Phone, and Email
- ✓ Dependent
  - Updates to the following fields should be validated: Name, Gender, Relationship, and Birth Date.
- ✓ Coverage Span
  - Updates to the following fields should be validated: Employee Id, Employee Category, and Deductible
- ✓ Product Span
  - Updates to the following fields should be validated: Employee Id, Employee Category, and Election

Samples

Existing Employer

E|12345|996|12-3456789|Acme Inc.|123 Acme Ln|Suite 3700|Draper|UT|84020|801-555-1234|801-555-5678|contactus@acmeinc.com|John Doe|VP Human Resources

Updated Employer

E|12345|12-3456789|**Acme Corp.**|**916 Jones Dr**|**Suite 9800**|**Carlton**|**SC**|**26320**|**475-333-5789**|**475-333-1568**|**contactus@acmecorp.com**|**Larry Drew**|**Owner**

Existing Insured

I|A123456|Doe|John|E|Sr|M|19770404|999-99-9998|123 Home Ln|Apt 14|American Fork|UT|84003|PO Box 1234||American Fork|UT|84003|801-555-5555|801-555-1233|johndoe@abc.com

Updated Insured

I|A123456|Doe|**Lana**|E||**F**|**19651210**|999-99-9998|**915 House Dr**|||**Smallville**|**GA**|**75303**|||||**437-537-9861**|**437-526-8494**|**lanadoe@abc.com**

Existing Dependent

D|A123456-02|A123456|Spouse|Doe|Jane|L||F|19791012|999-99-8888|20230101|20240101

Updated Dependent

D|A123456-02|A123456|**Child**|Doe|**Jeremy**|||**M**|**20120621**|999-99-8888|20230101|20240101

Existing Coverage Span
C|A123456_20230101_12345_HSA5000|A123456|12345_HSA5000|6789|T650|Non-Union|20230101|20240101|HSA|Family|3000.00

Updated Coverage Span
C|A123456_20230101_12345_HSA5000|A123456|12345_HSA5000|6789|**C650**|**Union**|20230101|20240101|HSA|Family|**2500.00**

Existing Product Span
S|A123456_20230101_12345_LPHCRA5000|A123456|12345_LPHCRA5000|6789|T650|Non-Union|20230101|20240101|LPHCRA|Family|1000.00| TRUE

Updated Product Span
S|A123456_20230101_12345_LPHCRA5000|A123456|12345_LPHCRA5000|6789|**C650**|**Union**|20230101|20240101|LPHCRA|Family|**2000.00**|TRUE

Additional Scenarios

These scenarios are intended to validate other variables that fall outside standard enrollment practices. Deliver complete record sets only. HealthEquity may request the following scenarios:

- ✓ Enrollment not Aligned with Medical
  - In some instances, enrollment in a HealthEquity product will not align with the medical renewal dates. These validation scenarios are designed to ensure that the correct dates can be passed when this occurs.

HealthEquity Standard Deduction File Specification

A guide for the HealthEquity deduction file integration process including file specifications and processing standards

TABLE OF CONTENTS

OVERVIEW

This document describes the requirements for inbound reimbursement account (HCRA, LPHCRA, DCRA, and Incentive-Based HRA) deduction data exchange with HealthEquity. It details the automated process for transmitting deduction data to HealthEquity and defines the deduction requirements and data elements that comprise the file format.

FILE DELIVERY AND STRUCTURE

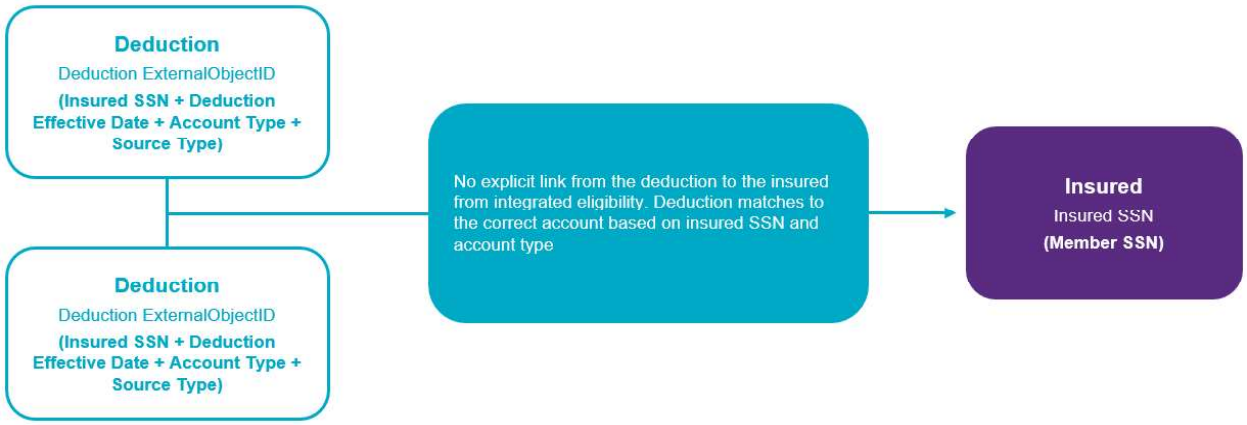
File format delimiter	*Pipe or comma*
Delivery frequency	
Day delivered	
File encryption (Y | N)	
File naming convention	*DED_[DATASOURCE]_[PARTNER].[YYYYMMDDhhmmss].txt [.pgp|.gpg|.asc]*
First validation file	
First production file	

FORMATTING REQUIREMENTS

Type	Detail
Alphabetic Fields (A)	Consists only of letters of the alphabet
Alphanumeric Fields (AN)	A combination of alphabetic and numeric characters (*Example AB123456*).
Currency Fields (C)	Currency fields should not include the dollar sign ($). Values should not be smaller than one cent, or two places to the right of the decimal. Please use a period as the fraction separator. Commas and spaces should not be sent in the value (*Example 1200.15*). Do not send $1.200,15; 1200,15; or $1,200.1516.
Date Fields (D)	Date fields are always in YYYYMMDD format without punctuation. Leading zeroes should be included on months or days that are less than 2 digits long (*Example February 5, 2023 should be 20230205*). Please ensure dates are sent as 8 digit integers.
Numeric Fields (N)	Values for SSN should contain dashes (-) as part of their formatting (*Example 123-45-6789*).
String Value Field Length	HealthEquity system limit for any given field is 250 characters.

RECORD RELATIONSHIP DIAGRAMS

DEDUCTIONS MATCHING BASED ON INSURED SSN



LINKING DEDUCTION FILE RECORDS

LINKING EXTERNAL OBJECT IDS

Each record type described in the Record Relationship Diagrams links to the appropriate account via SSN. HealthEquity will create a unique deduction EOID based on the data elements sent in the file.

RECORD TYPES

The deduction file layout contains one record type. HealthEquity creates the unique EOID based on the values below:

Deduction EOID:

- Insured SSN + deduction effective date + account type + source type

MATCHING DEDUCTIONS TO MEMBERS

Insured SSN matching: HealthEquity will use the insured SSN, account type, and deduction effective date to match the deduction to the member. This is not an explicit match. Deductions received prior to enrollment will not automatically link to the member once enrollment is established.

FILE LAYOUT

Field Name	Column	Type	Required	Description	Notes
Deduction	0	A	R	Record Type *D*	This identifies the record as a deduction record
SSN	1	N	R	Member's social security number *123-45-6789*	This identifies the member's account in the HealthEquity system.
DeductionEffectiveDate	2	D	R	The date on which the deduction is effective *20230214*	This date will be visible to the member as well as drive to which plan year deductions are applied.
Plan Year	3	N	R	The plan year in which the deduction will be posted 2023	This year will drive to which account the deduction will be posted. The plan year field is also used to capture the plan year to which deductions should be applied in the event of an off-calendar plan year. The value passed in this field should be the calendar year in which the plan year ends. If, for example, a plan runs from 8/1/2023 to 7/31/2024, then this field should be populated with the value '2024'.
SourceType	4	A	R	Indicates whether the deduction is an employer funded or employee funded amount *EE*	There should be one record on the file for each transaction. Two separate records will be required when an individual has both employer and employee deposits. Accepted values are EE or ER.
Amount	5	C	R	The amount of the deduction *100.00*	
MemberFirstName	6	A	R	Member's first name *John*	This field is used to match the deduction to the correct member.
MemberLastName	7	A	R	Members last name *Smith*	This field is used to match the deduction to the correct member.
AccountType	8	A	R	Account type to which the deduction will apply *HCRA*	This unique plan identifier will need to be populated for each record passed on the file. Acceptable values are HRA*, HCRA, LPHCRA, DCRA, FSA, LPFSA, DCFSA and DFSA.

Field Name	Column	Type	Required	Description	Notes
					*Note: HRA should only be included if the plan is Incentive based or has variable amounts. Plans with amounts based on Coverage Tier are configured by HealthEquity during the plan setup.

Sample

D|123-45-6789|20230214|2023|EE|100.00|John|Smith|HCRA

Deduction Effective Date

The deduction effective date determines the plan year to which the deduction should be applied.

It is important that all deduction files report a deduction effective date within plan year. For example, while final payroll deductions will take place in December 2023, the final deduction file may not be sent to HealthEquity until January 2024. It is important that the final deduction file report deduction effective dates within 2023 to ensure the deductions are applied to 2023 plans. This applies to calendar year and off calendar year plans.

Duplicate Deductions

If more than one record is passed on a file for a given member with the same account type, deduction effective date, and source type, the records will be treated as duplicates and only one deduction record will be processed by HealthEquity. This is true even if the deduction amount differs from record to record. The employer (or source) should configure their system so that multiple employee (EE) or employer (ER) deduction records for the same account type and deduction effective date are not passed. These records should be summed together and passed as a single record for each source type and account type on the deduction file.

- ✓ UNIQUE RECORDS

  D|123-45-6789|**20231206**|2023|**EE**|75.00|Jane|Doe|**HCRA**
  D|123-45-6789|**20231220**|2023|**EE**|75.00|Jane|Doe|**HCRA**

- ✓ DUPLICATE RECORDS

  D|123-45-6789|**20231220**|2023|**EE**|25.00|Jane|Doe|**HCRA**
  D|123-45-6789|**20231220**|2023|**EE**|15.00|Jane|Doe|**HCRA**
  D|123-45-6789|**20231220**|2023|**EE**|35.00|Jane|Doe|**HCRA**

Zero Dollar Deductions

Zero dollars deductions passed on the deduction file will be processed and reflect in the member portal. The employer or vendor should configure the deduction file to *exclude $0.00 employer and employee deductions*.

Employee Not Enrolled

Deduction records for employees who are not present in the HealthEquity system will not load. The HealthEquity production team will work with the employer to resolve errors around enrollment and apply deductions.

Deduction Reversal

Positive and negative deduction records can be included on the file. However, for a negative deduction to be processed correctly, it must be sent with a different deduction effective date than the original deduction that it is intended to reverse.

- ✓ **Original Deduction**

  D|123-45-6789|**20230103**|2023|EE|**75.00**|Jane|Doe|HCRA

- ✓ **Reversal**

  D|123-45-6789|**20230117**|2023|EE|**-75.00**|Jane|Doe|HCRA

TRAILER RECORD

Field Name	Column	Type	Required	Description	Notes
RecordType	0	A	R	Should always be sent as 'T' *T*	Indicates this is a Trailer record.
RecordCount	1	N	R	The count of all records sent on the file *1200*	Include the Trailer record in the count.
FileDate	2	D	R	The date the file was created *20210424*	This will typically be the same date as in the file name.

Sample

T|1200|20230424

Trailer records are optional; however, they can be used as an initial point of file processing validation. If the record counts in the file do not match those sent in the trailer record, the file will fail to process.

FILE VALIDATION

VALIDATION FILES

We require at least one deduction validation file prior to processing a production file. Once the first validation file is received, it will be mapped by the HealthEquity Engineering Team. A date for a production file can be established

once both parties are comfortable the file behaves appropriately in the validation environment. Our expectation is that validation data will be provided to validate all recommended scenarios. Validation eligibility will need to be delivered to HealthEquity in order to validate the deduction file.

VALIDATION EXPECTATIONS

HealthEquity requires a 30 days window from the receipt of the initial validation file to complete its mapping. HealthEquity recommends an additional 30 days for cycle validation. Recommended validation scenarios will be provided. Failure to validate will likely result in problems with production data, which is much more difficult to resolve than validation data.

Our assumption is that partners wish to test their own file accuracy. HealthEquity does not assume responsibility for validating the quality of the data being sent. It is assumed that partners validate data prior to transmitting validation and production files.

PRODUCTION FILE

HealthEquity recommends sending the first production file as early in the process as possible to allow for additional validation prior to loading in production. Validation and production files should be delivered in the same format. ***It may take up to 4 business days from receipt for the initial production file to be loaded at HealthEquity.***

PRODUCTION CORRELATION DETAIL REPORT

A separate correlation output report will be provided with an .html or .csv file detailing record level warnings, informational messages or data errors associated with the processed file. The correlation output report will be placed on the HealthEquity Hub and the partner / employer will be provided login credentials and URL path to retrieve the report. A sample correlation report can be provided upon request. Questions about the contents of the report should be directed to your Account Manager.

VALIDATION SCENARIOS

HealthEquity requires validation to ensure that data is mapped and processed correctly. To assist with validation, HealthEquity will provide the HealthEquity Deduction Validation Scenarios document. This spreadsheet will be shared between the partner and HealthEquity to track progress and document validation results. HealthEquity attempts to limit the possible errors that occur on deduction files. It is critical that all validation scenarios are reviewed and accounted for. Additional information on potential validation scenarios is available below.

ACCOUNT TYPE

These scenarios are intended to validate the partner's ability to send deductions for all applicable account types. Based on the account offering, the partner may be asked to send deductions for the following account types:

- ✓ HCRA
- ✓ LPHCRA
- ✓ DCRA
- ✓ HRA*

*Note: HRA should only be included if the plan is Incentive based or has variable amounts. Plans with amounts based on Coverage Tier are configured by HealthEquity during the plan setup.

SOURCE TYPE

This scenario is intended to validate the partner's ability to send employer and employee source type deduction records. If only one source type applies, this scenario will be omitted from the validation plan.

DEDUCTION REVERSAL

This scenario is intended to validate the partner's ability to reverse deductions that are sent in error. In order for a negative deduction to be processed, it must be sent with a different deduction effective date than the original deduction that it is intended to reverse.

- ✓ **Original Deduction**

  D|123-45-6789|**20230103**|2023|EE|**75.00**|Jane|Doe|**HCRA**

- ✓ **Reversal**

  D|123-45-6789|**20230117**|2023|EE|**-75.00**|Jane|Doe|**HCRA**

FINAL PAYROLL

To validate that deduction effective dates will be reported within plan year on the final deduction file, HealthEquity may request that a validation file for the final payroll cycle of the plan year be generated.

OFF CALENDAR PLANS

For off calendar plans, HealthEquity will require validating that deductions for both calendar years across which the plan year spans. These will be used to verify that HealthEquity is routing deductions to the correct plan year as indicated by the deduction effective date.

- ✓ **Deduction for 2023**

  D|123-45-6789|**20230717**|**2023**|EE|75.00|Jane|Doe|HCRA

- ✓ **Deduction for 2024**

  D|123-45-6789|**20240327**|**2024**|EE|75.00|Jane|Doe|HCRA

Standard Service Levels

HSA, Reimbursement Accounts and Commuter

If HealthEquity ("HQY") fails to meet the applicable service levels identified in the table below within the corresponding service level in any given calendar quarter during the Term, then Employer will be entitled to the corresponding service credit. All service credits will be calculated based upon on the aggregate amount of actual applicable monthly administration fees charged to Employer under the Agreement in the quarter in which the service level is not achieved and will be applied against future fees owed under this Agreement. All service levels are calculated quarterly based on HQY's book of business data. Service levels only apply to full calendar quarters that occur during the Term. For service levels associated with Reimbursement Accounts, application of service credits is contingent on HQY's timely receipt of funding and fees due.

Service Level	Measurement	Description	Service Credit %
Call Response Time	80% within ≤ 30 seconds	Percentage of Member calls answered within 30 seconds	2%
Call Abandonment	≤ 5%	Total Member calls abandoned DIVIDED BY total calls received	2%
Claims processing (non-HSA*)	98%	Percentage of claims processed within 5 business days	1%
Claims accuracy (non-HSA*)	98%	Percentage of claims accuracy	1%
Card Fulfillment	95%	Percentage of cards mailed within 5 business days upon transmission of clean enrollment file to card production vendor	1%
Card Processing (HSA)	98%	HSA Card transactions processed within one business day of swipe DIVIDED BY total card transactions in that same day.	2%**
Inbound File Processing Timeliness	98% within ≤ 2 business days	Percentage of inbound files accepted and processed after date received by HQY	2%
Web and EFT Contribution (HSA)	98% within ≤2 business days	Contribution - complete contribution submissions credited to account upon receipt of the contribution funds via the web or EFT	2%**
Paper Contribution (HSA)	95% within ≤5 business days	Contribution - complete contribution submissions credited to account upon receipt via paper with appropriately completed allocation instructions	2%**
Website Availability	99%	Availability Level of Website hosted by HQY - With the exception of (i) planned maintenance and other planned outages, (ii) problems with the Employer's equipment or facilities, (iii) any outages due to the acts or omissions of Employer or its members, and (iv) any other outages due to causes beyond the control of HQY or which are not reasonably foreseeable by HQY (including, without limitation, interruption or failure of telecommunication or digital transmission links, hostile network attacks, network congestion or other failures), HQY shall maintain at least a 99% availability of the HQY websites to Employer and its members during the Agreement (the "Availability Level").	2%
Client Satisfaction	Average score of 3 out of 5	Client satisfaction with account management via semi-annual survey based on a minimum of 5 responses each survey. If the average score falls below 3, service provider will be given an opportunity to "cure", via a documented project plan, the issue within a reasonable period of time, and if unsuccessful, fees at risk will apply. *Client-Specific	1%
* Excludes ESP plans **This credit is only applicable: (1) if HQY is administering your HSA and (2) to the applicable HSA Admin fees.			
		MAXIMUM AGGREGATE AMOUNT OF SERVICE CREDIT (% OF QUARTERLY FEES)	**18%**

Standard Service Levels

COBRA & Direct Bill

If WageWorks ("WW") fails to meet the applicable service levels identified in the table below within the corresponding service level in any given calendar quarter during the Term, then Employer will be entitled to the corresponding service credit. All service credits will be calculated based upon on the aggregate amount of actual applicable monthly administration fees charged to Employer under the Agreement in the quarter in which the service level is not achieved and will be applied against future fees owed under this Agreement. All service levels are calculated quarterly based on WW's book of business data. Service levels only apply to full calendar quarters that occur during the Term. In order to receive any service credit, Employer must not be past due on any invoices.

Service Level	Measurement	Description	Service Credit %
Call Response Time	80% within ≤ 30 seconds	Percentage of Member calls answered within 30 seconds	1%
Call Abandonment	≤ 5%	Total Member calls abandoned DIVIDED BY total calls received	1%
COBRA Employer Premium Statement and Fee Invoice	98% distributed ≤ 7 business days after the first day of the month	Percentage of COBRA employer premium statements and fee invoices distributed after the 1st of the month	1%
Payment Posting Timeliness	98% posted by WW ≤ 3 business days	Percentage of payments posted by WW after payments received by WW	1%
Inbound File Processing Timeliness	98% ≤ 2 business days	Percentage of inbound files accepted and processed after date received by WW	1%
Website Availability	99%	Availability Level of Website hosted by WW - With the exception of (i) planned maintenance and other planned outages, (ii) problems with the employer's equipment or facilities, (iii) any outages due to the acts or omissions of employers or its members, and (iv) any other outages due to causes beyond the control of WW or which are not reasonably foreseeable by WW (including, without limitation, interruption or failure of telecommunication or digital transmission links, hostile network attacks, network congestion or other failures), WW shall maintain at least a 99% availability of the WW websites to employer and its members during the Agreement (the "Availability Level").	1%
Client Satisfaction	Average score of 3 out of 5	Client satisfaction with account management via semi-annual survey based on a minimum of 5 responses each survey. If the average score falls below 3, service provider will be given an opportunity to "cure", via a documented project plan, the issue within a reasonable period of time, and if unsuccessful, fees at risk will apply. *Client-Specific	1%
MAXIMUM AGGREGATE AMOUNT OF SERVICE CREDIT (% OF QUARTERLY FEES)			**7%**

Claim filing requirements

HealthEquity®

READ BEFORE SUBMITTING YOUR REIMBURSEMENT FORM.
DO NOT FAX THESE INSTRUCTIONS WITH YOUR REIMBURSEMENT FORM.

Required information for reimbursement

The IRS requires you to substantiate all claims with documentation. The documentation must detail the healthcare expenses and include five key data points:

1. Name of provider
2. Name of patient
3. Description of services
4. Date(s) of service. The paid date may or may not be the same as the date of service; the date of service is required.
5. The cost of the service

Requests submitted without the above information cannot be processed.

Claim reimbursement checklist:

- For faster processing, submit a claim online via the 'Claims & Payments' tab. Otherwise, complete the claim form in its entirety. Incomplete requests cannot be processed.
- Include the required documentation that includes all of the five key data requirements listed above.
- Sign the claim form.
- Keep the original receipts for your records and send copies to us.

For faster payment, add EFT by logging in to www.MyHealthEquity.com or submitting the direct deposit form.

Over-the-counter medications

Over-the-counter (OTC) drugs and medicines along with menstrual care products are now eligible without a written prescription as of January 1, 2020. A Letter of Medical Necessity (LMN) will still be required for vitamins and dual-purpose OTC items. The LMN is good for a 12 month period and must be dated on or before services rendered. The LMN form is available under Forms and Docs in the Member Portal. Note: OTCs purchased in 2019 will still require the written prescription and do not allow for menstrual products.

Online claims submissions and account information

For assistance submitting claims online, to access your account, or for assistance in adding your EFT, please contact HealthEquity® member services at 877.472.8632, they are available every hour of every day to assist you, or log in to www.MyHealthEquity.com.

FSA/HRA Reimbursement Form

HealthEquity®

Mail or fax completed forms to:

Address: **HealthEquity, Attn: Reimbursement Accounts**
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020

Fax: 801.999.7829 (cover sheet not required)

For faster processing, enter the claim and upload required documentation using the 'Claims & Payments' tab on the member portal.

Account holder information

Company name	Last 4 of SSN or HealthEquity ID number		
Last name	First name		M.I.
Street address	City	State	ZIP
Email address (required)	Daytime phone ( )	Work phone ( )	

Reimbursement information

Patient name	Service provider	Actual date(s) of service Start date:____ /____/____ End date:____ /____ /____
Description		Amount $
Patient name	Service provider	Actual date(s) of service Start date:____ /____/____ End date:____ /____ /____
Description		Amount $
Patient name	Service provider	Actual date(s) of service Start date:____ /____/____ End date:____ /____ /____
Description		Amount $
Patient name	Service provider	Actual date(s) of service Start date:____ /____/____ End date:____ /____ /____
Description		Amount $
Patient name	Service provider	Actual date(s) of service Start date:____ /____/____ End date:____ /____ /____
Description		Amount $
Patient name	Service provider	Actual date(s) of service Start date:____ /____/____ End date:____ /____ /____
Description		Amount $
	TOTAL AMOUNT REQUESTED	$

CERTIFICATION AND AUTHORIZATION:

I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible expenses incurred by myself or an eligible dependent while I was a participant in the plan. (Patient & Relationship is assumed to be Self unless otherwise indicated.) I have already received these products and services and confirm that by requesting reimbursement here that I have not and will not seek reimbursement of this expense from any other plan or party. If I am covered under more than one healthcare account, reimbursement will be made according to the payment order determined by those plans and as stated on the website. Use of this service indicates my acceptance of the HealthEquity's User Agreement.

Reimbursement method

☐ **Option 1—Check**
This method is slower. Please allow 7–10 business days to receive your check.

☐ **Option 2—Use the verified electronic funds transfer (EFT) account already tied to my HealthEquity® FSA.**
(If an EFT is not on file, a check will be sent. Please allow 7-10 business days for the check to arrive.)

☐ **Option 3—Transfer the funds to the following account.**
(**Note**: E-mail address is required for EFT.)

Account type: ☐ Checking ☐ Savings

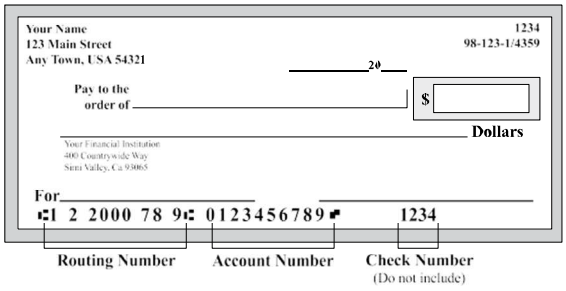
Financial institution:_____

City/state:_____

Routing number:_____

Account number:_____

A copy of a voided check must be included to verify banking information otherwise a check will be sent and a $2.00 fee may apply.



Note: Please attach proper documentation to this form. An explanation of benefits or itemized receipt is required. Documentation must include the actual date(s) of service, patient name, provider's name, description of service, and the cost. If you have additional expenses, please complete an additional form. **Send only copies of receipts.** Keep original receipts for your records.

Update: Effective Jan. 1, 2011, a letter of medical necessity may be required for medicinal over-the-counter items (i.e. aspirin). A letter of medical necessity form is available on your HealthEquity® member portal.

Reimbursement requests can also be made online at www.MyHealthEquity.com.

Claim filing requirements

HealthEquity®

READ BEFORE SUBMITTING YOUR REIMBURSEMENT FORM.
DO NOT FAX THESE INSTRUCTIONS WITH YOUR REIMBURSEMENT FORM.

Required information for reimbursement

The IRS requires you to substantiate all claims with documentation. The documentation must detail the expenses and include five key data points:

1. Name of provider
2. Name of dependent receiving care
3. Type of care
4. Date(s) of care. The paid date may or may not be the same as the date of care; the date of care is required.
5. The cost of the care

Requests submitted without the above information cannot be processed.

Claim reimbursement checklist:

- Complete the claim form in its entirety. For faster processing, submit a claim online via the 'Claims & Payments' tab.
- Include the required documentation with all of the five key data points listed above.
- Sign the claim form. A signature is required.
- Keep the original receipts for your records and send copies to us.

For faster payment, add EFT information to the reimbursement method portion of this form.

Dependent care account (DCRA)

DCRA claims can be set up on recurring payments. Please select the 'Annual' option on the claim form and provide an itemized receipt of the monthly amount paid, OR the care provider can sign the claim form. A claim will be entered for your total election amount and payments will be sent out as deposits are made into your account.

Note: A claim form signed by your care provider certifying the request replaces the need for documentation or an itemized receipt.

Online claims submissions and account information

For faster processing, log in to your account at www.MyHealthEquity.com and select 'Add Claim' from the 'Claims & Payments' tab. Follow the prompts and upload your documentation to the claim. For assistance submitting claims online, accessing your account or adding an EFT, please contact member services. They are available every hour of every day at 877.472.8632 to assist you.

(DCRA) Dependent care reimbursement account reimbursement form

HealthEquity®

Mail or fax completed forms to:

Address: **HealthEquity, Attn: Claims**
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020

Fax: 801.999.7829

***Required fields**

For faster processing, enter the claim and upload required documentation using the 'Claims & Payments' tab on the member portal.

Account holder information

Company name	Last 4 of SSN or HealthEquity account number	Phone number	
Last name	First name		M.I.
Street address	City	State	ZIP

Select option (This is required. If an option is not selected, your request may be denied.)

☐ **Annual:** Select this option if your dependent care amount will meet or exceed your elected annual amount. With this option, you will not need to submit a new form each month. HealthEquity will send automatic payments up to the election amount as deposits become available in your account. Payments will continue unless you request they be discontinued. You will need to submit a new DCRA reimbursement form at the beginning of each new plan year.

☐ **Pay as-you-go:** Select this option if you are requesting a one-time reimbursement. With this option, you will need to submit a new form for each request. If your caregiver completes and signs below, you do not need to include an itemized statement. If requesting for multiple dependents, each dependent must be listed on a separate line. Future dates of care may be scheduled out for payment.

Claim form must be filled out in its entirety. Incomplete forms may be denied.

Date incurred*
Begin date:_____ /_____ /_______ End date:_____ /_____ /_______ Service provider* ________________

Dependent's name*	Dependent's date of birth*	Out of pocket cost*	
	____ /_____ /_______	$	☐ Weekly ☐ Monthly ☐ Annually

Type of service*
☐ Before/after school care ☐ Day care ☐ Pre-K ☐ Other ________________

Date incurred*
Begin date:_____ /_____ /_______ End date:_____ /_____ /_______ Service provider* ________________

Dependent's name*	Dependent's date of birth*	Out of pocket cost*	
	____ /_____ /_______	$	☐ Weekly ☐ Monthly ☐ Annually

Type of service*
☐ Before/after school care ☐ Day care ☐ Pre-K ☐ Other ________________

Date incurred*
Begin date:_____ /_____ /_______ End date:_____ /_____ /_______ Service provider* ________________

Dependent's name*	Dependent's date of birth*	Out of pocket cost*	
	____ /_____ /_______	$	☐ Weekly ☐ Monthly ☐ Annually

Type of service*
☐ Before/after school care ☐ Day care ☐ Pre-K ☐ Other ________________

***Required fields** ***TOTAL REQUESTED AMOUNT:** $

Provider certification

Please have the daycare provider sign below or attach itemized receipts.

Provider certification: I certify that I am a qualified care provider as defined by the Internal Revenue Code and that the expenses for services claimed above have been provided.

Provider signature (replaces the need for other proof of services.)	Date
Second provider signature (Note: This is for a second caregiver, if you have more than one.)	Date

CERTIFICATION AND AUTHORIZATION:

I certify that the information on this page is accurate and complete. I am requesting reimbursement for work-related dependent care expenses incurred by an eligible dependent (for a child under the age of 13 or other dependents that are physically and mentally incapable of taking care of themselves) while I was a participant in the plan. These services have already been provided and confirm that by requesting reimbursement here that I have not and will not seek reimbursement of this expense from any other plan or party. Use of this service indicates my acceptance of the HealthEquity's User Agreement.

Reimbursement method

☐ **Option 1—Check**
This method is slower. Please allow 7–10 business days to receive your check. **A $2.00 fee will be deducted from your dependent care reimbursement account (DCRA).**

☐ **Option 2—Use the verified electronic funds transfer (EFT) account already tied to my HealthEquity® HRA/FSA. Select this option for faster payment or filled out the information on Option 3.**
Note: If an EFT is not on file, a check will be sent and a $2.00 fee may apply. Please allow 7-10 business days for the check to arrive.

☐ **Option 3—Transfer the funds to the following account.** (Email address is required for EFT)

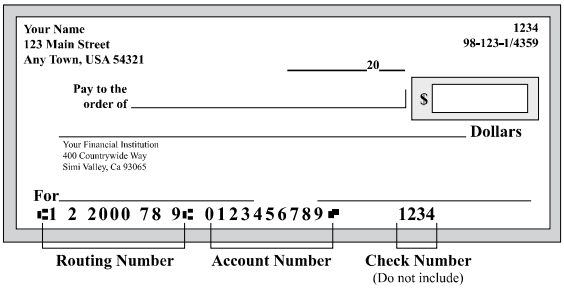
Account type: ☐ Checking ☐ Savings

Financial institution:_____

City/state:_____

Routing number:_____

Account number:_____



A copy of a voided check must be included to verify banking information otherwise a check will be sent and a $2.00 fee may apply. If you are updating EFT info once claims have been processed, you must call to update.

If you have additional expenses, please complete an additional form. **Send only copies of receipts.** Keep original receipts for your records.

If you have questions, contact HealthEquity® member services at 877.472.8632, they are available every hour of every day to assist you.

HealthEquity

15 West Scenic Pointe Drive Suite 400
Draper, UT 84020

Phone: 866-346-5800
Fax: 801-999-7829

If you have any questions, please call 866-346-5800.
Your account information is also available at www.HealthEquity.com

Reimbursement Account Statement

Period: 12/01/2022 to 12/31/2022
Statement Print Date: 01/01/23

JOHN SMITH
123 SOUTH 456 STREET
ABC TOWN, NY, 12345

2022 FSA

Account Name	Election	Deposits YTD	Total Pd YTD	Balance
2022 FSA	1,400.00	1,445.83	1,400.00	0.00

Date	Description of Transaction	Deposit or (Withdrawal)	Account Balance
		Starting Balance	$ 16.00
12/03/2022	Deposit	58.34	16.00
12/08/2022	Payment for claim 1234567-0001 for Jane Smith	(16.00)	0.00
12/16/2022	Deposit	58.18	0.00
12/31/2022	Deposit	104.17	0.00
		Ending Balance	0.00

2022 HRA

Account Name	Election	Deposits YTD	Total Pd YTD	Balance
2022 HRA	2,800.00	2,800.00	238.56	3,526.58

Date	Description of Transaction	Deposit or (Withdrawal)	Account Balance
		Starting Balance	$ 2,274.04
12/02/2022	Payment for claim 1234567-0002 for John Smith	(8.00)	2,266.04
12/02/2022	Payment for claim 1234567-0003 for Jane Smith	(30.00)	2,236.04
12/02/2022	Payment for claim 1234567-0004 for John Smith	(39.79)	2,196.25
12/02/2022	Payment for claim 1234567-0005 for Jane Smith	(69.67)	2,126.58
12/29/2022	Deposit	700.00	2,826.58
12/29/2022	Deposit	700.00	3,526.58
		Ending Balance	$ 3,526.58

2021 FSA

Account Name	Election	Deposits YTD	Total Pd YTD	Balance
2021 FSA	2,500.00	0.00	0.00	2,500.00

Date	Description of Transaction	Deposit or (Withdrawal)	Account Balance
		Starting Balance	$ 2,500.00
		Ending Balance	$ 2,500.00

Return of reimbursement account overpayment

HealthEquity®

Email, mail or fax completed forms to:

Address: **HealthEquity, Attn: Member Services**
PO Box 14374, Lexington, KY 40512

Fax: 520.844.7090 (cover sheet not required)

Primary account holder information

Employer name (if applicable)			
Last name	First name		M.I.
Street address	City	State	ZIP
Email address (required)	Daytime phone ( )	Last 4 of SSN or HealthEquity ID number	

Return of overpayment information

Account to apply overpayment to: ☐ FSA/LPFSA ☐ HRA ☐ DCRA ☐ HIA

Card transaction date	**Claim number**
Provider/Merchant	Amount $
Card transaction date	**Claim number**
Provider/Merchant	Amount $

Banking information (If no option is selected, form is void)

☐ **Option 1**—Check

Include a check payable to HealthEquity with this form and mail to:
HealthEquity, Attn: Client Services, PO Box 14374, Lexington, KY 40512

Please include "overpayment" in the memo line of your check and include which card transaction or claim number to reference payment.

When you provide a check as payment, you authorize HealthEquity to either use the information from your check to make a one-time, Back Office Conversion (BOC), electronic fund transfer from your account if eligible, or to process the payment as a check transaction. Funds processed via BOC may be withdrawn from your account as soon as the same day your payment is received.

☐ **Option 2**—One-time electronic funds transfer (EFT)

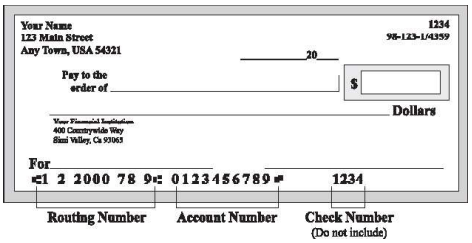
Fax this form and a copy of a voided check to:
HealthEquity, attn: Client Services, 520.844.7090.

Account type: ☐ Checking ☐ Savings Amount: $_____

Financial institution:_____

Routing number:_____ Account number:_____

Form must be accompanied by a copy of a voided or an actual check.



☐ **Option 3**—Use the verified EFT account already tied to my account.

Authorization

This form is required to correct an overpayment made for your reimbursement account. By signing below, I swear or affirm that the correction from my reimbursement account in the amount stated above is a correction of an overpayment resulting from a mistake of fact due to reasonable cause.

Name (please print)	Signature	Date

City of San Diego

CONTRACTOR STANDARDS

Pledge of Compliance

The City of San Diego has adopted a Contractor Standards Ordinance (CSO) codified in section 22.3004 of the San Diego Municipal Code (SDMC). The City of San Diego uses the criteria set forth in the CSO to determine whether a contractor (bidder or proposer) has the capacity to fully perform the contract requirements and the business integrity to justify the award of public funds. This completed Pledge of Compliance signed under penalty of perjury must be submitted with each bid and proposal. If an informal solicitation process is used, the bidder must submit this completed Pledge of Compliance to the City prior to execution of the contract. All responses must be typewritten or printed in ink. If an explanation is requested or additional space is required, Contractors must provide responses on Attachment A to the Pledge of Compliance and sign each page. Failure to submit a signed and completed Pledge of Compliance may render a bid or proposal non-responsive. In the case of an informal solicitation or cooperative procurement, the contract will not be awarded unless a signed and completed Pledge of Compliance is submitted. A submitted Pledge of Compliance is a public record and information contained within will be available for public review except to the extent that such information is exempt from disclosure pursuant to applicable law.

By signing and submitting this form, the contractor is certifying, to the best of their knowledge, that the contractor and any of its Principals have not within a five (5) year period – preceding this offer, been convicted of or had a civil judgement rendered against them for commission of a fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (Federal, State or local) contract or subcontract.

"Principal" means an officer, director, owner, partner or a person having primary management or supervisory responsibilities within the firm. The Contractor shall provide immediate written notice to the Procurement Contracting Officer handling the solicitation, at any time prior to award should they learn that this Representations and Certifications was inaccurate or incomplete.

This form contains 10 pages, additional information may be submitted as part of *Attachment A.*

A. BID/PROPOSAL/SOLICITATION TITLE:

Request for Proposal (RFP) for COBRA and Flexible Spending Account (FSA) Administration

10090182-25-G

B. BIDDER/PROPOSER INFORMATION:

HealthEquity, Inc.			
Legal Name		DBA	
121 W. Scenic Pointe Drive	Draper	UT	84020
Street Address	City	State	Zip
Louis Feinstein	(214) 524-27 7		
Contact Person, Title	Phone	Fax	

Provide the name, identity, and precise nature of the interest* of all persons who are directly or indirectly involved** in this proposed transaction (SDMC § 21.0103). Use additional pages if necessary.

* The precise nature of the interest includes:

- the percentage ownership interest in a party to the transaction,
- the percentage ownership interest in any firm, corporation, or partnership that will receive funds from the transaction,
- the value of any financial interest in the transaction,
- any contingent interest in the transaction and the value of such interest should the contingency be satisfied, and
- any philanthropic, scientific, artistic, or property interest in the transaction.

** Directly or indirectly involved means pursuing the transaction by:

- communicating or negotiating with City officers or employees,
- submitting or preparing applications, bids, proposals or other documents for purposes of contracting with the City, or
- directing or supervising the actions of persons engaged in the above activity.

NONE

Name Title/Position

City and State of Residence Employer (if different than Bidder/Proposer)

Interest in the transaction

Name Title/Position

City and State of Residence Employer (if different than Bidder/Proposer)

Interest in the transaction

Name Title/Position

City and State of Residence Employer (if different than Bidder/Proposer)

Interest in the transaction

Name Title/Position

City and State of Residence Employer (if different than Bidder/Proposer)

Interest in the transaction

Name Title/Position

City and State of Residence Employer (if different than Bidder/Proposer)

Interest in the transaction

Name Title/Position

City and State of Residence Employer (if different than Bidder/Proposer)

Interest in the transaction

Name | Title/Position

City and State of Residence | Employer (if different than Bidder/Proposer)

Interest in the transaction

Name | Title/Position

City and State of Residence | Employer (if different than Bidder/Proposer)

Interest in the transaction

Name | Title/Position

City and State of Residence | Employer (if different than Bidder/Proposer)

Interest in the transaction

C. OWNERSHIP AND NAME CHANGES:

1. In the past five ten (5) years, has your firm changed its name?
   ☐**Yes** ☑**No**

   If **Yes**, use Attachment A to list all prior legal and DBA names, addresses, and dates each firm name was used. Explain the specific reasons for each name change.

2. Is your firm a non-profit?
   ☐**Yes** ☑**No**

   If **Yes,** attach proof of status to this submission.

3. In the past five (5) years, has a firm owner, partner, or officer operated a similar business?
   ☐**Yes** ☑**No**

   If **Yes**, use Attachment A to list names and addresses of all businesses and the person who operated the business. Include information about a similar business only if an owner, partner, or officer of your firm holds or has held a similar position in another firm.

D. BUSINESS ORGANIZATION/STRUCTURE:

Indicate the organizational structure of your firm. Fill in only one section on this page. Use Attachment A if more space is required.

☑ **Corporation** Date incorporated: 9/18/2002 State of incorporation: Delaware

List corporation's current officers:
President: Jon Kessler - President and CEO
Vice Pres: Michael Fiore - EVP / CCO
Secretary: Del Ladd - EVP / GC and Secretary
Treasurer: James Lucania - EVP / CFO

Type of corporation: C ☑ Subchapter S ☐

Is the corporation authorized to do business in California: ☑**Yes** ☐**No**

If **Yes,** after what date: 05/25/2021

Is your firm a publicly traded corporation? ☑ **Yes** ☐ **No**

If **Yes,** how and where is the stock traded? HealthEquity is a publicly traded company (NASDAQ:HQY).

If **Yes**, list the name, title and address of those who own ten percent (10 %) or more of the corporation's stocks:

BlackRock, Inc., 50 Hudson Yards New York, NY 10001

The Vanguard Group, 100 Vanguard Blvd. Malvern, PA 19355

Do the President, Vice President, Secretary and/or Treasurer of your corporation have a third party interest or other financial interests in a business/enterprise that performs similar work, services or provides similar goods? ☐ **Yes** ☑ **No**

If **Yes,** please use Attachment A to disclose.

Please list the following:	Authorized	Issued	Outstanding
a. Number of voting shares:			
b. Number of nonvoting shares:			
c. Number of shareholders:			
d. Value per share of common stock:		Par	$
		Book	$
		Market	$

Limited Liability Company Date formed: _____ State of formation: _____

List the name, title and address of members who own ten percent (10%) or more of the company:

☐ **Partnership** Date formed: _____ State of formation: _____

List names of all firm partners:

☐ **Sole Proprietorship** Date started: _____

List all firms you have been an owner, partner or officer with during the past five (5) years. Do not include ownership of stock in a publicly traded company:

☐ **Joint Venture** Date formed: _____

List each firm in the joint venture and its percentage of ownership:

_____
_____
_____
_____

Note: To be responsive, each member of a Joint Venture or Partnership must complete a separate *Contractor Standards form*.

E. FINANCIAL RESOURCES AND RESPONSIBILITY:

1. Is your firm preparing to be sold, in the process of being sold, or in negotiations to be sold?
☐ **Yes** ☑ **No**

   If **Yes**, use Attachment A to explain the circumstances, including the buyer's name and principal contact information.

2. In the past five (5) years, has your firm been denied bonding?
☐ **Yes** ☑ **No**

   If **Yes**, use Attachment A to explain specific circumstances; include bonding company name.

3. In the past five (5) years, has a bonding company made any payments to satisfy claims made against a bond issued on your firm's behalf or a firm where you were the principal?
☐ **Yes** ☑ **No**

   If **Yes**, use Attachment A to explain specific circumstances.

4. In the past five (5) years, has any insurance carrier, for any form of insurance, refused to renew the insurance policy for your firm?
☐ **Yes** ☑ **No**

   If **Yes**, use Attachment A to explain specific circumstances.

5. Within the last five years, has your firm filed a voluntary petition in bankruptcy, been adjudicated bankrupt, or made a general assignment for the benefit of creditors?
☐ **Yes** ☑ **No**

   If **Yes**, use Attachment A to explain specific circumstances.

6. Are there any claims, liens or judgements that are outstanding against your firm?
☐ **Yes** ☑ **No**

   If **Yes,** please use Attachment A to provide detailed information on the action.

7. Please provide the name of your principal financial institution for financial reference. ~~By submitting a response to this Solicitation Contractor authorizes a release of credit information for verification of financial responsibility.~~

   Name of Bank: HealthEquity, Inc. is a publicly traded company. We wil_l provide financial information as_needed.

   Point of Contact:_____

   Address:_____

   Phone Number:_____

8. By submitting a response to a City solicitation, Contractor certifies that he or she has sufficient operating capital and/or financial reserves to properly fund the requirements identified in the solicitation. At City's request, Contractor will promptly provide to City

a copy of Contractor's most recent balance sheet and/or other necessary financial statements to substantiate financial ability to perform.

9. In order to do business in the City of San Diego, a current Business Tax Certificate is required. Business Tax Certificates are issued by the City Treasurer's Office. If you do not have one at the time of submission, one must be obtained prior to award.

   Business Tax Certificate No.: To be provided Year Issued: _____

F. PERFORMANCE HISTORY:

1. In the past five (5) years, has your firm been found civilly liable, either in a court of law or pursuant to the terms of a settlement agreement, for defaulting or breaching a contract with a government agency?
   ☐ **Yes** ☑ **No**

   If **Yes**, use Attachment A to explain specific circumstances.

2. In the past five (5) years, has a public entity terminated your firm's contract for cause prior to contract completion?
   ☐ **Yes** ☑ **No**

   If **Yes**, use Attachment A to explain specific circumstances and provide principal contact information.

3. In the past five (5) years, has your firm entered into any settlement agreement for any lawsuit that alleged contract default, breach of contract, or fraud with or against a public entity?
   ☐ **Yes** ☑ **No**

   If **Yes**, use Attachment A to explain specific circumstances.

4. Is your firm currently involved in any lawsuit with a government agency in which it is alleged that your firm has defaulted on a contract, breached a contract, or committed fraud?
   ☐ **Yes** ☑ **No**

   If **Yes**, use Attachment A to explain specific circumstances.

5. In the past five (5) years, has your firm, or any firm with which any of your firm's owners, partners, or officers is or was associated, been debarred, disqualified, removed, or otherwise prevented from bidding on or completing any government or public agency contract for any reason?
   ☐ **Yes** ☑ **No**

   If **Yes**, use *Attachment A* to explain specific circumstances.

6. In the past five (5) years, has your firm received a notice to cure or a notice of default on a contract with any public agency?

   ☐ **Yes** ☑ **No**

   If **Yes**, use Attachment A to explain specific circumstances and how the matter resolved.

7. Performance References:

Please provide a minimum of three (3) references familiar with work performed by your firm which was of a similar size and nature to the subject solicitation within the last five (5) years.

Please note that any references required as part of your bid/proposal submittal are in addition to those references required as part of this form.

Company Name: To be provided upon finalist notification.

Contact Name and Phone Number: _____

Contact Email: _____

Address: _____

Contract Date: _____

Contract Amount: _____

Requirements of Contract: _____

Company Name: To be provided upon finalist notification.

Contact Name and Phone Number: _____

Contact Email: _____

Address: _____

Contract Date: _____

Contract Amount: _____

Requirements of Contract: _____

Company Name: To be provided upon finalist notification.

Contact Name and Phone Number: _____

Contact Email: _____

Address: _____

Contract Date: _____

Contract Amount: _____

Requirements of Contract: _____

G. COMPLIANCE:

1. In the past five (5) years, has your firm or any firm owner, partner, officer, executive, or manager been criminally penalized or found civilly liable, either in a court of law or pursuant to the terms of a settlement agreement, for violating any federal, state, or local law in performance of a contract, including but not limited to, laws regarding health and safety, labor and employment, permitting, and licensing laws?
   ☐**Yes** ☑**No**

   If **Yes**, use Attachment A to explain specific circumstances surrounding each instance. Include the name of the entity involved, the specific infraction(s) or violation(s), dates of instances, and outcome with current status.

2. In the past five (5) years, has your firm been determined to be non-responsible by a public entity?
   ☐**Yes** ☑**No**

If **Yes**, use Attachment A to explain specific circumstances of each instance. Include the name of the entity involved, the specific infraction, dates, and outcome.

H. BUSINESS INTEGRITY:

1. In the past five (5) years, has your firm been convicted of or found liable in a civil suit for making a false claim or material misrepresentation to a private or public entity?
☐**Yes** ☑**No**

   If **Yes**, use Attachment A to explain specific circumstances of each instance. Include the entity involved, specific violation(s), dates, outcome and current status.

2. In the past five (5) years, has your firm or any of its executives, management personnel, or owners been convicted of a crime, including misdemeanors, or been found liable in a civil suit involving the bidding, awarding, or performance of a government contract?
☐**Yes** ☑**No**

   If **Yes**, use Attachment A to explain specific circumstances of each instance; include the entity involved, specific infraction(s), dates, outcome and current status.

3. In the past five (5) years, has your firm or any of its executives, management personnel, or owners been convicted of a federal, state, or local crime of fraud, theft, or any other act of dishonesty?
☐**Yes** ☑**No**

   If **Yes**, use Attachment A to explain specific circumstances of each instance; include the entity involved, specific infraction(s), dates, outcome and current status.

4. Do any of the Principals of your firm have relatives that are either currently employed by the City or were employed by the City in the past five (5) years?

   ☐**Yes** ☑**No**

   If **Yes,** please disclose the names of those relatives in Attachment A.

I. BUSINESS REPRESENTATION:

1. Are you a local business with a physical address within the County of San Diego?
☐**Yes** ☑**No**

2. Are you a certified Small and Local Business Enterprise certified by the City of San Diego?
☐**Yes** ☑**No**

   Certification #_____

3. Are you certified as any of the following:
   a. Disabled Veteran Business Enterprise Certification # No
   b. Woman or Minority Owned Business Enterprise Certification # No
   c. Disadvantaged Business Enterprise Certification # No

J. WAGE COMPLIANCE:

In the past five (5)years, has your firm been required to pay back wages or penalties for failure to comply with the federal, state or local **prevailing, minimum, or living wage laws**? ☐**Yes** ☑**No** If **Yes**, use Attachment A to explain the specific circumstances of each instance. Include the entity involved, the specific infraction(s), dates, outcome, and current status.

By signing this Pledge of Compliance, your firm is certifying to the City that you will comply with the requirements of the Equal Pay Ordinance set forth in SDMC sections 22.4801 through 22.4809.

K. STATEMENT OF SUBCONTRACTORS & SUPPLIERS:

Please provide the names and information for all subcontractors and suppliers used in the performance of the proposed contract, and what portion of work will be assigned to each subcontractor. ~~Subcontractors may not be substituted without the written consent of the City.~~ Use Attachment A if additional pages are necessary. If no subcontractors or suppliers will be used, please write "Not Applicable."

Company Name: None retained specifically for City of San Diego

Address: _____

Contact Name: _____ Phone: _____ Email: _____

Contractor License No.: _____ DIR Registration No.: _____

Sub-Contract Dollar Amount: $_____(per year) $_____(total contract term)

Scope of work subcontractor will perform: _____

Identify whether company is a subcontractor or supplier: _____

Certification type (check all that apply): ☐DBE ☐DVBE ☐ELBE ☐MBE ☐SLBE ☐WBE ☐Not Certified

Contractor must provide valid proof of certification with the response to the bid or proposal to receive participation credit.

Company Name: _____

Address: _____

Contact Name: _____ Phone: _____ Email: _____

Contractor License No.: _____ DIR Registration No.: _____

Sub-Contract Dollar Amount: $_____(per year) $_____(total contract term)

Scope of work subcontractor will perform: _____

Identify whether company is a subcontractor or supplier: _____

Certification type (check all that apply): ☐DBE ☐DVBE ☐ELBE ☐MBE ☐SLBE ☐WBE ☐Not Certified

Contractor must provide valid proof of certification with the response to the bid or proposal to receive participation credit.

L. STATEMENT OF AVAILABLE EQUIPMENT: NOT APPLICABLE

~~A full inventoried list of all necessary equipment to complete the work specified may be a requirement of the bid/proposal submission.~~

~~By signing and submitting this form, the Contractor certifies that all required equipment included in this bid or proposal will be made available one week (7 days) before work shall commence. In instances where the required equipment is not owned by the Contractor, Contractor shall explain how the equipment will be made available before the commencement of work. The City of San~~

~~Diego reserves the right to reject any response, in its opinion, if the Contractor has not demonstrated he or she will be properly equipped to perform the work in an efficient, effective matter for the duration of the contract period.~~

M. TYPE OF SUBMISSION: This document is submitted as:

☑ Initial submission of *Contractor Standards Pledge of Compliance*

☐ Initial submission of *Contractor Standards Pledge of Compliance* as part of a Cooperative agreement

☐ Initial submission of *Contractor Standards Pledge of Compliance* as part of a Sole Source agreement

☐ Update of prior *Contractor Standards Pledge of Compliance* dated _____.

Complete all questions and sign below.

Under penalty of perjury under the laws of the State of California, I certify that I have read and understand the questions contained in this Pledge of Compliance, that I am responsible for completeness and accuracy of the responses contained herein, and that all information provided is true, full and complete to the best of my knowledge and belief. I agree to provide written notice to the Purchasing Agent within five (5) business days if, at any time, I learn that any portion of this Pledge of Compliance is inaccurate. Failure to timely provide the Purchasing Agent with written notice is grounds for Contract termination.

I, on behalf of the firm, further certify that I and my firm will comply with the following provisions of SDMC section 22.3004:

(a) I and my firm will comply with all applicable local, State and Federal laws, including health and safety, labor and employment, and licensing laws that affect the employees, worksite or performance of the contract.

(b) I and my firm will notify the Purchasing Agent in writing within fifteen (15) calendar days of receiving notice that a government agency has begun an investigation of me or my firm that may result in a finding that I or my firm is or was not in compliance with laws stated in paragraph (a).

(c) I and my firm will notify the Purchasing Agent in writing within fifteen (15) calendar days of a finding by a government agency or court of competent jurisdiction of a violation by the Contractor of laws stated in paragraph (a).

(d) I and my firm will notify the Purchasing Agent in writing within fifteen (15) calendar days of becoming aware of an investigation or finding by a government agency or court of competent jurisdiction of a violation by a subcontractor of laws stated in paragraph (a).

(e) I and my firm will cooperate fully with the City during any investigation and to respond to a request for information within ten (10) working days.

Failure to sign and submit this form with the bid/proposal shall make the bid/proposal non-responsive. In the case of an informal solicitation, the contract will not be awarded unless a signed and completed *Pledge of Compliance* is submitted.

Michael Fiore	Michael Fiore (Aug 6, 2024 09:12 EDT)	Aug 6, 2024
Name and Title	Signature	Date

City of San Diego
CONTRACTOR STANDARDS
Attachment "A"

Provide additional information in space below. Use additional Attachment "A" pages as needed. Each page must be signed. Print in ink or type responses and indicate question being answered.

N/A

I have read the matters and statements made in this Contractor Standards Pledge of Compliance and attachments thereto and I know the same to be true of my own knowledge, except as to those matters stated upon information or belief and as to such matters, I believe the same to be true. I certify under penalty of perjury that the foregoing is true and correct.

Michael Fiore	Michael Fiore (Aug 6, 2024 09:12 EDT)	Aug 6, 2024
Print Name, Title	Signature	Date

The City of SAN DIEGO

EQUAL OPPORTUNITY CONTRACTING (EOC)

1200 Third Avenue, Suite 200 • San Diego, CA 92101
Phone: (619) 236-6000 • Fax: (619) 236-5904

WORK FORCE REPORT

The objective of the *Equal Employment Opportunity Outreach Program*, San Diego Municipal Code Sections 22.3501 through 22.3517, is to ensure that contractors doing business with the City, or receiving funds from the City, do not engage in unlawful discriminatory employment practices prohibited by State and Federal law. Such employment practices include, but are not limited to unlawful discrimination in the following: employment, promotion or upgrading, demotion or transfer, recruitment or recruitment advertising, layoff or termination, rate of pay or other forms of compensation, and selection for training, including apprenticeship. Contractors are required to provide a completed *Work Force Report (WFR).*

NO OTHER FORMS WILL BE ACCEPTED

CONTRACTOR IDENTIFICATION

Type of Contractor: ☐ Construction ■ Vendor/Supplier ☐ Financial Institution ☐ Lessee/Lessor ☐ Consultant ☐ Grant Recipient ☐ Insurance Company ☐ Other

Name of Company: HealthEquity, Inc.

ADA/DBA:

Address (Corporate Headquarters, where applicable): 15 W. Scenic Pointe Dr.

City: Draper County: Salt Lake State: UT Zip: 84020

Telephone Number: N/A Fax Number: N/A

Name of Company CEO: Jon Kessler

Address(es), phone and fax number(s) of company facilities located in San Diego County **(if different from above):**

Address: None

City: County: State: Zip:

Telephone Number: Fax Number: Email:

Type of Business: Third Party Administrator Type of License: N/A

The Company has appointed: Calvin Sun

As its Equal Employment Opportunity Officer (EEOO). The EEOO has been given authority to establish, disseminate and enforce equal employment and affirmative action policies of this company. The EEOO may be contacted at:

Address: 15 W. Scenic Pointe Dr., Draper, UT 84020

Telephone Number: 312.775.2677 Fax Number: N/A Email: csun@healthequity.com

---

☐ One San Diego County (or Most Local County) Work Force - Mandatory

■ Branch Work Force *

☐ Managing Office Work Force

Check the box above that applies to this WFR.

**Submit a separate Work Force Report for all participating branches. Combine WFRs if more than one branch per county.*

I, the undersigned representative of HealthEquity, Inc.
(Firm Name)

Salt Lake , Utah hereby certify that information provided
(County) *(State)*

herein is true and correct. This document was executed on this 24th day of July , 20 24

(Authorized Signature) *(Print Authorized Signature Name)*

WORK FORCE REPORT – Page 2

NAME OF FIRM: HealthEquity, Inc. DATE: 7/24/24

OFFICE(S) or BRANCH(ES): Irving, TX COUNTY: Dallas

INSTRUCTIONS: For each occupational category, indicate number of males and females in every ethnic group. Total columns in row provided. Sum of all totals should be equal to your total work force. Include all those employed by your company on either a full or part-time basis. The following groups are to be included in ethnic categories listed in columns below:

(1) Black or African-American
(2) Hispanic or Latino
(3) Asian
(4) American Indian or Alaska Native
(5) Native Hawaiian or Pacific Islander
(6) White
(7) Other race/ethnicity; not falling into other groups

Definitions of the race and ethnicity categories can be found on Page 4

ADMINISTRATION OCCUPATIONAL CATEGORY	(1) Black or African American		(2) Hispanic or Latino		(3) Asian		(4) American Indian/ Nat. Alaskan		(5) Pacific Islander		(6) White		(7) Other Race/ Ethnicity	
	(M)	(F)	(M)	(F)	(M)	(F)	(M)	(F)	(M)	(F)	(M)	(F)	(M)	(F)
Management & Financial	5	10	6	7	4	1	0	0	0	0	10	8	1	2
Professional	14	49	10	19	15	10	1	0	0	1	40	34	6	10
A&E, Science, Computer	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Technical	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sales	1	0	0	0	0	0	0	0	0	0	0	1	0	0
Administrative Support	24	118	11	24	4	5	0	0	0	0	10	20	5	37
Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Crafts	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Operative Workers	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Laborers*	0	0	0	0	0	0	0	0	0	0	0	0	0	0

*Construction laborers and other field employees are not to be included on this page

Totals Each Column	44	177	27	50	23	16	1	0	0	1	60	63	12	49

Grand Total All Employees	523

Indicate by Gender and Ethnicity the Number of Above Employees Who Are Disabled:

Disabled	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Non-Profit Organizations Only:

Board of Directors														
Volunteers														
Artists														

WORK FORCE REPORT – Page 3

NAME OF FIRM: HealthEquity, Inc. DATE: 7/24/24

OFFICE(S) or BRANCH(ES): Irving, TX COUNTY: Dallas

INSTRUCTIONS: For each occupational category, indicate number of males and females in every ethnic group. Total columns in row provided. Sum of all totals should be equal to your total work force. Include all those employed by your company on either a full or part-time basis. The following groups are to be included in ethnic categories listed in columns below:

(1) Black or African-American
(2) Hispanic or Latino
(3) Asian
(4) American Indian or Alaska Native
(5) Native Hawaiian or Pacific Islander
(6) White
(7) Other race/ethnicity; not falling into other groups

Definitions of the race and ethnicity categories can be found on Page 4

TRADE OCCUPATIONAL CATEGORY	(1) Black or African American		(2) Hispanic or Latino		(3) Asian		(4) American Indian/ Nat. Alaskan		(5) Pacific Islander		(6) White		(7) Other Race/ Ethnicity	
	(M)	(F)	(M)	(F)	(M)	(F)	(M)	(F)	(M)	(F)	(M)	(F)	(M)	(F)
Brick, Block or Stone Masons	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carpenters	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Carpet, Floor & Tile Installers Finishers	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cement Masons, Concrete Finishers	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Construction Laborers	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Drywall Installers, Ceiling Tile Inst	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Electricians	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Elevator Installers	0	0	0	0	0	0	0	0	0	0	0	0	0	0
First-Line Supervisors/Managers	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Glaziers	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Helpers; Construction Trade	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Millwrights	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Misc. Const. Equipment Operators	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Painters, Const. & Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pipelayers, Plumbers, Pipe & Steam Fitters	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Plasterers & Stucco Masons	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Roofers	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Security Guards & Surveillance Officers	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sheet Metal Workers	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Structural Metal Fabricators & Fitters	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Welding, Soldering & Brazing Workers	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Workers, Extractive Crafts, Miners	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals Each Column	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Grand Total All Employees 0

Iindicate By Gender and Ethnicity the Number of Above Employees Who Are Disabled:

Disabled	0	0	0	0	0	0	0	0	0	0	0	0	0	0

The City of SAN DIEGO

Work Force Report

HISTORY

The Work Force Report (WFR) is the document that allows the City of San Diego to analyze the work forces of all firms wishing to do business with the City. We are able to compare the firm's work force data to County Labor Force Availability (CLFA) data derived from the United States Census. CLFA data is a compilation of lists of occupations and includes the percentage of each ethnicity we track (American Indian or Alaska Native, Asian, Black or African-American, Native Hawaiian or Pacific Islander, White, and Other) for each occupation. Currently, our CLFA data is taken from the 2010 Census. In order to compare one firm to another, it is important that the data we receive from the consultant firm is accurate and organized in the manner that allows for this fair comparison.

WORK FORCE & BRANCH WORK FORCE REPORTS

When submitting a WFR, especially if the WFR is for a specific project or activity, we would like to have information about the firm's work force that is actually participating in the project or activity. That is, if the project is in San Diego and the work force is from San Diego, we want a San Diego County Work Force Report[1]. By the same token, if the project is in San Diego, but the work force is from another county, such as Orange or Riverside County, we want a Work Force Report from that county[2]. If participation in a San Diego project is by work forces from San Diego County and, for example, from Los Angeles County and from Sacramento County, we ask for separate Work Force Reports representing your firm from each of the three counties.

MANAGING OFFICE WORK FORCE

Equal Opportunity Contracting may occasionally ask for a Managing Office Work Force (MOWF) Report. This may occur in an instance where the firm involved is a large national or international firm but the San Diego or other local work force is very small. In this case, we may ask for both a local and a MOWF Report[1, 3]. In another case, when work is done only by the Managing Office, only the MOWF Report may be necessary.[3]

TYPES OF WORK FORCE REPORTS:

Please note, throughout the preceding text of this page, the superscript numbers one [1], two [2] & three [3]. These numbers coincide with the types of work force report required in the example. See below:

[1] One San Diego County (or Most Local County) Work Force – Mandatory in most cases

[2] Branch Work Force *

[3] Managing Office Work Force

**Submit a separate Work Force Report for all participating branches. Combine WFRs if more than one branch per county.*

RACE/ETHNICY CATEGORIES

American Indian or Alaska Native – A person having origins in any of the peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.

Asian – A person having origins in any of the peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American – A person having origins in any of the Black racial groups of Africa.

Native Hawaiian or Pacific Islander – A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White – A person having origins in any of the peoples of Europe, the Middle East, or North Africa.

Hispanic or Latino – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin.

Exhibit A: Work Force Report Job Categories – Administration

Refer to this table when completing your firm's Work Force Report form(s).

Management & Financial
Advertising, Marketing, Promotions, Public Relations, and Sales Managers
Business Operations Specialists
Financial Specialists
Operations Specialties Managers
Other Management Occupations
Top Executives

Professional
Art and Design Workers
Counselors, Social Workers, and Other Community and Social Service Specialists
Entertainers and Performers, Sports and Related Workers
Health Diagnosing and Treating Practitioners
Lawyers, Judges, and Related Workers
Librarians, Curators, and Archivists
Life Scientists
Media and Communication Workers
Other Teachers and Instructors
Postsecondary Teachers
Primary, Secondary, and Special Education School Teachers
Religious Workers
Social Scientists and Related Workers

Architecture & Engineering, Science, Computer
Architects, Surveyors, and Cartographers
Computer Specialists
Engineers
Mathematical Science Occupations
Physical Scientists

Technical
Drafters, Engineering, and Mapping Technicians
Health Technologists and Technicians
Life, Physical, and Social Science Technicians
Media and Communication Equipment Workers

Sales
Other Sales and Related Workers
Retail Sales Workers
Sales Representatives, Services
Sales Representatives, Wholesale and Manufacturing
Supervisors, Sales Workers

Administrative Support
Financial Clerks
Information and Record Clerks
Legal Support Workers
Material Recording, Scheduling, Dispatching, and Distributing Workers
Other Education, Training, and Library Occupations
Other Office and Administrative Support Workers
Secretaries and Administrative Assistants
Supervisors, Office and Administrative Support Workers

Services
Building Cleaning and Pest Control Workers
Cooks and Food Preparation Workers
Entertainment Attendants and Related Workers
Fire Fighting and Prevention Workers
First-Line Supervisors/Managers, Protective Service Workers
Food and Beverage Serving Workers
Funeral Service Workers
Law Enforcement Workers
Nursing, Psychiatric, and Home Health Aides
Occupational and Physical Therapist Assistants and Aides
Other Food Preparation and Serving Related Workers
Other Healthcare Support Occupations
Other Personal Care and Service Workers
Other Protective Service Workers
Personal Appearance Workers
Supervisors, Food Preparation and Serving Workers
Supervisors, Personal Care and Service Workers
Transportation, Tourism, and Lodging Attendants

Crafts
Construction Trades Workers
Electrical and Electronic Equipment Mechanics, Installers, and Repairers
Extraction Workers
Material Moving Workers
Other Construction and Related Workers
Other Installation, Maintenance, and Repair Occupations
Plant and System Operators
Supervisors of Installation, Maintenance, and Repair Workers
Supervisors, Construction and Extraction Workers
Vehicle and Mobile Equipment Mechanics,

Installers, and Repairers
Woodworkers

Operative Workers
Assemblers and Fabricators
Communications Equipment Operators
Food Processing Workers
Metal Workers and Plastic Workers
Motor Vehicle Operators
Other Production Occupations
Printing Workers
Supervisors, Production Workers
Textile, Apparel, and Furnishings Workers

Transportation
Air Transportation Workers
Other Transportation Workers
Rail Transportation Workers
Supervisors, Transportation and Material Moving Workers
Water Transportation Workers

Laborers
Agricultural Workers
Animal Care and Service Workers
Fishing and Hunting Workers
Forest, Conservation, and Logging Workers
Grounds Maintenance Workers
Helpers, Construction Trades
Supervisors, Building and Grounds Cleaning and Maintenance Workers
Supervisors, Farming, Fishing, and Forestry Workers

Exhibit B: Work Force Report Job Categories-Trade

Brick, Block or Stone Masons
Brickmasons and Blockmasons
Stonemasons

Carpenters

Carpet, floor and Tile Installers and Finishers
Carpet Installers
Floor Layers, except Carpet, Wood and Hard Tiles
Floor Sanders and Finishers
Tile and Marble Setters

Cement Masons, Concrete Finishers
Cement Masons and Concrete Finishers
Terrazzo Workers and Finishers

Construction Laborers

Drywall Installers, Ceiling Tile Inst
Drywall and Ceiling Tile Installers
Tapers

Electricians

Elevator Installers and Repairers

First-Line Supervisors/Managers
First-line Supervisors/Managers of Construction Trades and Extraction Workers

Glaziers

Helpers, Construction Trade
Brickmasons, Blockmasons, and Tile and Marble Setters
Carpenters
Electricians
Painters, Paperhangers, Plasterers and Stucco
Pipelayers, Plumbers, Pipefitters and Steamfitters
Roofers
All other Construction Trades

Millwrights
Heating, Air Conditioning and Refrigeration Mechanics and Installers
Mechanical Door Repairers

Control and Valve Installers and Repairers

Other Installation, Maintenance and Repair Occupations

Misc. Const. Equipment Operators
Paving, Surfacing and Tamping Equipment Operators
Pile-Driver Operators
Operating Engineers and Other Construction Equipment Operators

Painters, Const. Maintenance
Painters, Construction and Maintenance
Paperhangers

Pipelayers and Plumbers
Pipelayers
Plumbers, Pipefitters and Steamfitters

Plasterers and Stucco Masons

Roofers

Security Guards & Surveillance Officers

Sheet Metal Workers

Structural Iron and Steel Workers

Welding, Soldering and Brazing Workers
Welders, Cutter, Solderers and Brazers
Welding, Soldering and Brazing Machine Setter, Operators and Tenders

Workers, Extractive Crafts, Miners

Cobra & Flexible Spending Account Adm Services

Final Audit Report 2024-12-31

Created:	2024-12-31
By:	Jerry Gibbs (jggibbs@sandiego.gov)
Status:	Signed
Transaction ID:	CBJCHBCAABAAGK11DNMw_FOWYD1kdw_ke5nrfddQLUle

"Cobra & Flexible Spending Account Adm Services" History

Document created by Jerry Gibbs (jggibbs@sandiego.gov)
2024-12-31 - 7:00:28 PM GMT- IP address: 134.238.190.205

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Signature Date: 2024-12-31 - 7:15:05 PM GMT - Time Source: server- IP address: 156.29.3.11

Document emailed to bradyt@sandiego.gov for signature
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2024-12-31 - 7:51:20 PM GMT- IP address: 107.77.228.112

Signer bradyt@sandiego.gov entered name at signing as Thomas J. Brady
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Document e-signed by Thomas J. Brady (bradyt@sandiego.gov)
Signature Date: 2024-12-31 - 7:52:22 PM GMT - Time Source: server- IP address: 107.77.228.112

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