

Third Party Administration & PPO Network Request for Proposal

City of San Luis, AZ

December 29, 2025



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CBIZ Employee Benefits
A Division of CBIZ Benefits & Insurance Services, Inc.

1765 E Skyline Dr | Tucson | AZ | 85718



I. Introduction

Client Name

City of San Luis Employee Benefits Trust

The City of San Luis, Arizona was founded in 1930 and incorporated in 1979. San Luis is an Arizona general law city, operating under the Council-Manager form of government. The Mayor serves a 4-year term, and six Council members serve staggered 4-year terms.

Located at Arizona's southwest corner of the Colorado River, San Luis borders California and San Luis Rio Colorado, Sonora, Mexico. With a population of 37,207, daily cross-border activity shapes its culture, economy, and environment.

The City employs about 355 full-time and 9 part-time staff, offering comprehensive benefits including medical, dental, vision, life insurance, STD/LTD and supplemental coverage. San Luis operates a self-funded health insurance program managed by the City of San Luis Employee Benefits Trust, overseen by five trustees with executive advisors from HR, Finance, and the City Manager.

Client Information

Address	800 E. Cesar Chavez Blvd., San Luiz, AZ 85349
Covered Population	348
Eligibility	First of the month following date of hire
Employer Contributions	90% Employee, 80% Dependents
Funding	ASO with Personify, renting BCBSAZ Network
Stop Loss Vendor	Nationwide Life Insurance Co./ Ryan Specialty
Pharmacy Benefit Manager	Liviniti and RxCompass

Current Benefit Administration

The City of San Luis Employee Benefits Trust currently offers its eligible employees and dependents a single PPO Plan along with a Mexico plan. The current TPA is Personify Health using the BCBS of AZ PPO Network. The Mexico Network plan is through Siarmed and integrated with Personify Health. PBM Services are provided through Liviniti and RxCompass. Stop loss is carved out through Nationwide/Ryan Specialty.

Requested Services and Objective

The City of San Luis Employee Benefits Trust seeks proposals for Third Party Administration (TPA) services with a robust PPO network for its self-funded medical and dental plans (i.e., Medical ASO, Dental ASO, Cobra Administration and U.S. based PPO Network). The City will evaluate proposals based upon the following focus areas:

1. Experience working with public sector employers and the ability to support U.S. and Mexico based provider networks

2. Exceptional customer service, superior account management, compliance, and regulatory support
3. Accurate and timely claims administration
4. Smooth implementation and transition support
5. Competitive and transparent pricing
6. Modern consumer engagement tools and robust population management services
7. Seamless integration with a robust PPO network, Mexico-based network and Liviniti PBM
8. Ability to administer the City’s current plan designs, alternative plan designs, and integration with third party point solutions
9. Timely and accurate reporting

Contact and Timeline

Direct all communications concerning this Request for Proposal to CBIZ. Under no circumstances may a vendor contact the City of San Luis, its staff or the Trustees of the City of San Luis Employee Benefits Trust Board regarding this RFP. Submit all RFP questions by email to Jennifer Aragon and Debbie Jamison by 01/12/2026. Questions submitted after this date or via phone message will not be addressed. CBIZ will respond directly to the vendor and only via email. Addendums or clarifications will be provided via email to all vendors that have expressed interest or have provided a proposal.

CBIZ RFP Contacts	Jennifer Aragon – jaragon@cbiz.com Debbie Jamison – djamison@cbiz.com
CBIZ Producer(s)	Dave Madden – david.madden@cbiz.com
Plan Effective Date	7/1/2026
Proposal Due Date	1/19/2026
RFP Questions Due	1/12/2026
RFP Decision Date	By: 3/25/2026

Interviews and Best and Final

The City of San Luis Employee Benefits Trust reserves the right, upon review of submitted proposals, to negotiate directly with vendors. This may, but not necessarily, include interviews, requests for clarification, or best and final pricing.

II. General Specifications

Plan Effective Date and Anniversary Date

The effective date is July 1, 2026; anniversary dates will be July 1st of subsequent years

Commissions

Proposals should not include commissions to CBIZ.

Guaranteed Rates and Renewals

The city prefers a proposal with a fee guarantee or rate cap over multiple years. The City of San Luis requires that administrative fee changes may only be implemented on the anniversary date (July 1 of each year). All fees or pricing changes must be provided to the City of San Luis, in writing, at least six months prior to the anniversary date of each year.

Run Out Services

Upon termination of this contract, the selected vendor agrees to process runout claims for at least twelve months with no additional fees including assisting the City of San Luis by providing transition data and files to subsequent vendors.

Plan Designs and Reporting

The selected vendor agrees to administer the City of San Luis' current plan designs and provide the City and CBIZ access to detailed monthly claims and utilization reports.

Rights to Records

All claim records and eligibility data used by the carrier in its role as claim administrator shall remain the property of the City of San Luis Employee Benefits Trust as Plan Sponsor.

Confidentiality Agreement

Information relative to this RFP may not be released to parties external to this process without the written consent of the City of San Luis and CBIZ. In addition, CBIZ and the City of San Luis agree to hold the information you provide in the strictest confidence and will not share your proposal responses with others outside of our respective organizations.

Vendors Errors/Omissions

Neither the City of San Luis nor CBIZ will be responsible for errors or omissions made in your proposal. You will be permitted to submit only one proposal. You may not revise or withdraw your submitted proposal after the deadline date. After that, revisions to your original submission will not be allowed except as requested by CBIZ or the City of San Luis.

III. Instructions

Submit seven (7) printed/bound copies and one (1) electronic copy on a thumb drive to the CBIZ contacts in Section I by the due date. The proposals must be received by the CBIZ office no later than the RFP due date. Proposals received after the RFP due date will not be considered. Please provide a comprehensive proposal that includes **details** and **narrative explanations** for the following topics.

All proposals should include at least three (3) references to include client name, industry, size and contact information, should the city wish to contact a reference prior to awarding.

You may use any format you prefer, but ensure your response addresses each area thoroughly. Please limit examples and supporting documentation to items that directly support the topic:

1. Experience with Public Sector Employers and U.S./Mexico Network

- a. Share your experience serving public sector clients and managing coverage across U.S. and Mexico networks.

2. Customer Service, Account Management, and Compliance Support

- a. Explain your approach to delivering exceptional customer service to members (i.e., Spanish speaking members, understanding how the benefits work, limits/exclusions, resolving provider/claim issues, prior authorization requirements) and steering members to the highest quality providers with best cost when services are not available in their community.
- b. Describe your approach to account management and how you will help the City meet its needs, including regulatory and compliance requirements (i.e., SBCs, SPD, ACA reporting, Mental Health Parity, Medicare Part D, etc.). Outline any additional fees within your pricing document.
- c. Provide information about the account management team and other key personnel that will support the City's plan.

3. Claims Administration and Integration

- a. Describe how you ensure accurate and timely claims processing, including how you support an independent audit. Outline any additional fees within your pricing document.
- b. Describe your claim fiduciary services and outline any additional fees within your pricing document.
- c. Explain your ability to coordinate with Liviniti (e.g., eligibility file, accumulator sharing etc.) and an external stop loss vendor (e.g., data feed, reimbursement coordination etc.). Outline any set-up or ongoing fees within your pricing document.

4. Implementation

- a. Describe your implementation process, timing and how you will support the City and its employees to ensure a smooth transition (i.e., prior authorizations, continuation of care, network disruptions, accumulator history). Please provide a sample implementation timeline assuming a 7/1/26 go-live date and award date of 3/25/26.

5. Pricing and Fee Guarantee

- a. Provide a one-two page itemized breakdown (by year) of your pricing including any programs or additional services that are billed through the claim wire (e.g., as a percentage of savings or other cost / utilization structure).

- b. Provide an outline of any implementation credits, wellness credits, claims guarantees and performance guarantees related to your proposal.

6. Consumer Engagement and Population Health Management

- a. Outline the tools and services you offer to drive member engagement and improve overall member experience with the plans.
- b. Describe your population health management program (in-house or outsourced), including wellbeing services. Outline any additional fees within your pricing document.

7. Provider Network Capabilities

- a. Provide an overview of your proposed PPO network. Include a geo-access report (i.e., distance to PCP, Hospital, MH/SA, Convenience Care Clinic, Specialist) and a comparison of the City's top utilized facilities and providers. Geo access report is not required if proposing to use the City's current PPO network provider - BCBS of AZ.
- b. Affirm your smooth integration with the proposed PPO network(s) and Mexico-based networks (i.e., Siarmed or IMS). If you are not currently integrated with the proposed network (U.S. or Mexico), please confirm your ability to do so and what it would entail to achieve working integration to administer the City's plans. Outline any set-up or ongoing fees within your pricing document.

8. Alternative Plan Design and Third-Party Solutions

- a. Explain your ability to administer alternative plan designs (e.g., copay only, PPO, QHDHP with HSA, Narrow Network, RBP) and integrate with third-party point solutions (e.g., Carrum COE, Virta, Hinge Health, Esurgeries, etc.). Outline any set-up or ongoing fees within your pricing document.

9. Reporting

- a. Describe your reporting capabilities, including timing and direct portal access for the City and CBIZ. Outline any additional set-up or ongoing fees within your pricing document.

V. Attachments


The following documents are attachments to this RFP:

- A. Current U.S. Benefit Summary**
- B. Current Mexico Benefit Summary**
- C. Top Provider List**
- D. Top Facility List**



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-221-8942 or visit us at www.trans-western.com. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-221-8942 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0	See the Common Medical Events chart below for your costs and services this plan covers.
Are there services covered before you meet your deductible ?	Not Applicable.	This plan does not have a deductible .
Are there other deductibles for specific services?	No.	You don't have to meet other deductibles for specific services.
What is the out-of-pocket limit for this plan ?	Not Applicable.	This plan does not have an out-of-pocket limit .
What is not included in the out-of-pocket limit ?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider ?	Yes. All medical services must be rendered by Hospital Santa Margarita. Please contact Transwestern at (800) 221-8942 for more information.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$10 co-pay	Not covered	Maximum of 5 office visits per calendar year combined with specialist visits.
	Specialist visit	\$10 co-pay	Not covered	Maximum of 5 visits per year combined with primary care visits. Must be approved prior to appointment.
	Preventive care/screening/immunization	No charge	Not covered	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for. Preventive services do not include healthcare related services that are provided as a result of illness, injury or congenital defect.
If you have a test	Diagnostic test (x-ray, blood work)	\$10 co-pay	Not covered	No charge if performed during office visit or hospitalization; otherwise \$10 co-payment per visit per patient. Maximum of 5 procedures/test per calendar
	Imaging (CT/PET scans, MRIs)	\$50 co-pay for CT scan and \$100 co-pay for MRI	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.transwestern.com	Generic drugs	\$5 co-pay	Not covered	Maximum of 10 Generic and Brand Rx combined per calendar year.
	Preferred brand drugs	\$20 co-pay	Not covered	Maximum of 10 Generic and Brand Rx combined per calendar year.
	Non-preferred brand drugs	Not covered	Not covered	None
	Specialty drugs	Not covered	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$50 co-pay	Not covered	Maximum of 2 visit per year
	Physician/surgeon fees	\$10 co-pay	Not covered	Maximum of 2 visit per year
If you need immediate medical attention	Emergency room care	\$100 per hospitalization per patient	Not covered	Maximum of 1 ER visit per year

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.trans-western.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	Not covered	Not covered	None
	Urgent care	\$50 <u>co-pay</u>	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150 <u>co-pay</u> per surgical hospitalization.	Not covered	Confinement of 18 hours or more. 1 inpatient stay per calendar year.
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	None
	Inpatient services	Not covered	Not covered	None
If you are pregnant	Office visits	\$10 <u>co-pay</u>	Not covered	Prenatal and Postnatal Care office visits
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	\$150 <u>co-pay</u> per patient	Not covered	48 hours following a vaginal delivery 96 hours following a cesarean delivery
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	None
	Rehabilitation services	Not covered	Not covered	None
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	Not covered	Not covered	None
	Durable medical equipment	Not covered	Not covered	None
	Hospice services	Not covered	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- | | | |
|-----------------------|-------------------------|----------------------------|
| • Acupuncture | • Chiropractic Care | • Private duty nursing |
| • Bariatric Surgery | • Hearing Aids | • Routine eye care (Adult) |
| • Dental Care (Adult) | • Infertility treatment | • Routine Foot Care |
| • Cosmetic Surgery | • Long Term care | • Weight Loss Programs |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Coverage provided outside the United States contact Transwestern Insurance at (800) 221-8942 for Mexico coverage

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies are the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? **No.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-221-8942.

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About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist \[cost sharing\]](#) \$10
- Hospital (facility) [\[cost sharing\]](#) \$150
- Other [\[cost sharing\]](#) \$10

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,759
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In this example, Peg would pay:

<i>Cost Sharing</i>	
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Deductibles	\$0
Copayments	\$370
Coinsurance	\$0

<i>What isn't covered</i>	
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Limits or exclusions	\$60
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The total Peg would pay is	\$430
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Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist \[cost sharing\]](#) \$10
- Hospital (facility) [\[cost sharing\]](#) \$150
- Other [\[cost sharing\]](#) \$10

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$7,431
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In this example, Joe would pay:

<i>Cost Sharing</i>	
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Deductibles	\$0
Copayments	\$485
Coinsurance	\$0

<i>What isn't covered</i>	
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Limits or exclusions	\$2,685
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The total Joe would pay is	\$3,170
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Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist \[cost sharing\]](#) \$10
- Hospital (facility) [\[cost sharing\]](#) \$150
- Other [\[cost sharing\]](#) \$10

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$1,991
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In this example, Mia would pay:

<i>Cost Sharing</i>	
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Deductibles	\$0
Copayments	\$340
Coinsurance	\$0

<i>What isn't covered</i>	
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Limits or exclusions	\$1,007
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The total Mia would pay is	\$1,347
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.




The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-888-472-4352. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-888-472-4352 to request a copy.

Important Questions	Answers	Why This Matters:		
What is the overall deductible ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.		
Are there services covered before you meet your deductible ?	Yes, all services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .		
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.		
What is the out-of-pocket limit for this plan ?	<table border="1"> <tr> <td>Network Not Applicable</td> <td>Non-Network \$20,000/self only \$20,000/individual \$40,000/family</td> </tr> </table>	Network Not Applicable	Non-Network \$20,000/self only \$20,000/individual \$40,000/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their out-of-pocket limits until the overall family out-of-pocket limit has been met.
Network Not Applicable	Non-Network \$20,000/self only \$20,000/individual \$40,000/family			
What is not included in the out-of-pocket limit ?	Premiums , balance billing charges (unless balance billing is prohibited), health care this plan doesn't cover, and penalties for failure to obtain pre-certification for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .		
Will you pay less if you use a network provider ?	Yes. See www.hchealthbenefits.com or call 1-888-472-4352 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use a non-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use a non-network provider for some services (such as lab work). Check with your provider before you get services.		
Do you need a referral to see a specialist ?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .		

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.hchealthbenefits.com.

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$5 copay /visit	Not covered	Members must request a Specialist referral through Siarmed.
	Specialist visit	\$5 copay /visit	Not covered	
	Preventive care/screening/immunization	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	Inpatient: No charge Office, Outpatient, & Standalone facility: \$5 copay	Not covered	Network provider copay applies to services performed in the office.
	Imaging (CT/PET scans, MRIs)	\$25 copay /visit	Not covered	Precertification is required or the network benefit could be reduced by \$250; or the non-network benefit could be reduced by 40%.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.hchealthbenefits.com	Generic drugs	\$2/prescription	Purchases at a non-participating pharmacy require you to pay in full then submit a claim form for reimbursement.	Covers up to a 30-day supply (retail pharmacy).
	Formulary brand drugs	\$5/prescription		
	Non-formulary brand drugs	Not covered		
	Specialty drugs	Not covered		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$25 copay /visit	Not covered	Precertification is required or the network benefit could be reduced by \$250; or the non-network benefit could be reduced by 40%.
	Physician/surgeon fees	No charge	Not covered	None

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.hchealthbenefits.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	Services performed in Mexico (Siarmed): \$20 copay /visit <hr/> Services performed in the US:* \$150 copay /visit		The copay is waived if you are admitted to the hospital directly from the emergency room. * Non-network services are only covered in case of emergency. Out of pocket maximum will apply.
	Emergency medical transportation	No charge		
	Urgent care	\$20 copay /visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$50 copay /visit	50% coinsurance *	Precertification is required or the network benefit could be reduced by \$250; or the non-network benefit could be reduced by 40%. * Non-network services are only covered in case of emergency. Out of pocket maximum will apply.
	Physician/surgeon fees	No charge	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: \$5 copay /visit	Not covered	None
	Inpatient services	Fewer than 12 hours: \$25 copay /visit <hr/> More than 12 hours: \$50 copay /visit	50% coinsurance *	Precertification is required or the network benefit could be reduced by \$250; or the non-network benefit could be reduced by 40%. * Non-network services are only covered in case of emergency. Out of pocket maximum will apply.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.hchealthbenefits.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visits	Initial visit: \$5 <u>copay</u> <hr/> Subsequent visits: No charge	Not covered	Cost sharing does not apply for <u>network preventive care</u> services. Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	\$50 <u>copay</u> /visit	50% <u>coinsurance</u> *	<u>Precertification</u> is required for an inpatient stay that is in excess of 48 hours (vaginal delivery) or 96 hours (caesarean delivery) or the <u>network</u> benefit could be reduced by \$250; or the <u>non-network</u> benefit could be reduced by 40%. * <u>Non-network</u> services are only covered in case of emergency. Out of pocket maximum will apply.
If you need help recovering or have other special health needs	<u>Home health care</u>	Not covered	Not covered	No coverage for home health care.
	<u>Rehabilitation services</u>	\$5 <u>copay</u> /visit	Not covered	Limited to Physical, Pulmonary, and Speech therapies.
	<u>Habilitation services</u>	\$5 <u>copay</u> /visit	Not covered	
	<u>Skilled nursing care</u>	Not covered	Not covered	No coverage for skilled nursing care.
	<u>Durable medical equipment</u>	\$5 <u>copay</u> /visit	Not covered	Jobst stockings limited to 1 pair per calendar year. Mastectomy bras limited to 7 per calendar year.
	<u>Hospice services</u>	Not covered	Not covered	No coverage for Hospice Services.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to 1 exam per calendar year.
	Children's glasses	Not covered	Not covered	No coverage for children's glasses.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-up.

* For more information about limitations and exceptions, see the [plan](http://www.hchealthbenefits.com) or policy document at www.hchealthbenefits.com.

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental Care (Adult) / (Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S. and/or Mexico, unless otherwise indicated. Refer to your Plan Document and Summary Plan Description for additional details.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Habilitation services (Limited to physical, pulmonary, and speech therapies)
- Hearing Aid (Limited to \$1,500 per ear every 3 calendar years)
- Routine eye care (Adult) / (Child) (Limited to 1 exam/calendar year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-472-4352.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijigo holne' 1-888-472-4352.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.hchealthbenefits.com.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$5
- Hospital (facility) [copayment](#) \$50
- Other (Tests) [copayment](#) \$5

This EXAMPLE event includes services like:
[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$260

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$5
- Hospital (facility) [copayment](#) \$50
- Other (Brand drug) [copayment](#) \$5

This EXAMPLE event includes services like:
[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$220

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$5
- Hospital (facility) [copayment](#) \$50
- Other (Physical Therapy) [copayment](#) \$5

This EXAMPLE event includes services like:
[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$80
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$80

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Top Facility Providers By Amount Issued

Report ID: CL-0011

Ref # 2369161

Report Criteria Selected:

Self-Funded Group: S2923

Selected Custom Group: S0000THRUS9999

Prorate: Yes

Incurred Date: Current Plan Year

From: 07/01/2025

Thru: 06/30/2026

Plan Types: MEDONLY

Carrier: ALL

Check Type: (Normal)

Premium Option: No Premium

Reference No: 2369161

Generated By: Kirby Breath

Generated: 12/8/2025 11:25 AM

Top Facility Providers By Amount Issued

Report ID: CL-0011

Ref # 2369161

City of San Luis Employee Benefit Trust

Group: S2923 Plan Type: MED

Tax ID	Provider Name	Units	Submitted	Discount (\$/%)	Issued
866007596	Yuma Regional Medical Center	1,557	\$180,083.77	\$32,400.51 17.99%	\$131,484.81
851514572	Exceptional Health Care Yuma LLC	212	\$56,252.68	\$11,370.40 20.21%	\$42,057.77
815364325	SIARMED USA LLC	21	\$3,825.54	\$0.00 0.00%	\$3,825.54
860422559	Phoenix Childrens Hospital	4	\$5,654.00	\$1,672.76 29.59%	\$923.39
860800150	Mayo Clinic Arizona	679	\$104,931.70	\$62.80 0.06%	\$0.00
270036484	Banner Thunderbird Medical Center	922	\$23,378.80	\$11,689.40 50.00%	\$0.00
Subtotal:		3,395	\$374,126.49	\$57,195.87 15.29%	\$178,291.51
		3,395	\$374,126.49	\$57,195.87 15.29%	\$178,291.51

Top Providers By Amount Issued

Report ID: CL-0006

Ref # 2369161

Report Criteria Selected:

Self-Funded Group: S2923

Selected Custom Group: S0000THRUS9999

Prorate: Yes

Incurred Date: Current Plan Year

From: 07/01/2025

Thru: 06/30/2026

Plan Types: MEDONLY

Carrier: ALL

Check Type: (Normal)

Premium Option: No Premium

Reference No: 2369161

Generated By: Kirby Breath

Generated: 12/8/2025 11:25 AM

Top Providers By Amount Issued

Report ID: CL-0006

Ref # 2369161

City of San Luis Employee Benefit Trust

Group: S2923

Plan Type: MED

Tax ID	Provider Name	Units	Submitted	Issued
860800150	Mayo Clinic Arizona	12,326	\$958,711.33	\$338,725.14
866007596	Yuma Regional Medical Center	2,331	\$373,107.05	\$218,045.53
815364325	SIARMED USA LLC	3,061	\$176,018.75	\$161,294.42
851514572	Exceptional Health Care Yuma LLC	212	\$56,252.68	\$42,057.77
300947669	HY Holdings Inc	5	\$18,242.80	\$18,242.80
884050378	Aleracare Aic LLC	2,404	\$250,934.70	\$16,151.43
270036484	Banner Thunderbird Medical Center	932	\$75,358.80	\$7,935.81
721339762	Medcom Care Management Inc	41	\$6,756.00	\$6,756.00
883463577	Exceptional Physicians Group Yuma H	5	\$10,014.00	\$6,180.97
651170616	San Luis Walk In Clinic	503	\$10,492.86	\$5,145.68
815108515	Sierra Estrellas Emergency Physicians	4	\$6,958.00	\$4,314.41
860872873	Sonora Quest Laboratories	311	\$24,085.53	\$3,539.02
861031142	Yuma Cardiac Center PC	24	\$8,280.00	\$2,994.51
901116753	Banner University Physician Specialist	5	\$4,975.02	\$2,787.32
330851349	Integrated Behavioral Health Inc	5	\$3,075.10	\$2,460.08
271844121	Yuma Kids Clinic Pllc	44	\$5,820.00	\$2,450.06
201778316	Center For Orthopedic Research Education LLC	10	\$5,302.23	\$2,377.89
860893305	Sunset Community Health Center	132	\$5,277.85	\$2,179.25
264000683	Smi Imaging LLC	113	\$6,859.00	\$1,985.81
204879089	Up 2 Par Pllc	65	\$4,911.00	\$1,906.52
860768311	Yuma Cardiology Associates PC	14	\$6,380.00	\$1,558.99
845036349	Toca At Banner Health LLC	12	\$2,032.08	\$1,504.74
201291415	Phoenix Childrens Medical	24	\$3,976.00	\$1,487.59
813384145	South County Diagnostic Services LLC	16	\$1,503.32	\$1,291.36
463456054	Kaynak Medical Services LLC	12	\$4,113.00	\$1,203.76
320220946	Southwest Heart And Vascular Care LTD	10	\$4,372.00	\$1,016.49
934895258	Nextcare Arizona I JV LLC	23	\$3,763.00	\$1,003.29
860422559	Phoenix Childrens Hospital	5	\$6,516.00	\$999.90
861826692	Headway Michigan Behavioral Health Services, P.C.	8	\$2,201.22	\$980.84
440561981	Spencer Fane LLP	2	\$980.00	\$980.00
204373472	Young Hearts Of Yuma Inc	9	\$2,300.00	\$974.61
860657319	Banner Home Care	11	\$1,470.92	\$874.95
860814146	Peter Cheung MD	4	\$3,316.00	\$805.24
861040704	Zelis Claims Integrity LLC	3	\$2,628.81	\$788.65
840611484	Laboratory Corporation Of America	130	\$11,612.12	\$758.69
860376164	City Of San Luis Arizona	22	\$1,685.58	\$748.47
860621497	Valley Anesthesiology Consultants LTD	6	\$1,287.00	\$737.28
474332541	Institute of Manual Physical Therap	52	\$2,141.32	\$678.73
861004041	North Scottsdale Dermatology Assoc	10	\$2,526.00	\$601.02
463288665	Brain Solutions Pllc	8	\$1,300.00	\$593.50
202956536	Abdulkadir Hourani MD	791	\$3,684.00	\$574.51
861009738	Heart & Vascular Center Of Arizona	7	\$2,155.00	\$558.18
860837483	Desert Healthcare Services LLC	21	\$1,289.00	\$552.91
260446753	Arizona Digestive Health PC	4	\$1,529.00	\$542.78
208879735	Yuma Urology Center Pllc	11	\$2,273.00	\$498.89
860290535	Allergy Associates & Lab LTD	107	\$4,412.00	\$454.83
364951909	BJD Inc	8	\$2,269.00	\$418.33
20578942	Habib Rathle MD	8	\$700.00	\$412.98
463078722	Jessica Duggan PC DPM	8	\$1,647.35	\$348.56
860919727	MomDoc LLC	5	\$1,626.00	\$335.07
Subtotal:		23,884	\$2,099,121.42	\$871,815.56
All Other Providers		214	\$35,412.46	\$5,825.13
		24,098	\$2,134,533.88	\$877,640.69