

AGENDA ITEM SUMMARY

DATE: 12-08-08

DEPARTMENT: Planning

DEPT. HEAD SIGNATURE: _____



SUBJECT: Contract with Rich Caplan and Associates for Quigley Annexation Fiscal Analysis

AUTHORITY: ID Code _____ IAR _____ City Ordinance/Code _____
(IF APPLICABLE)

BACKGROUND/SUMMARY OF ALTERNATIVES CONSIDERED:

On November 24, 2008 the Council approved the selection of Rich Caplan and Associates to conduct the fiscal analysis of the Quigley Annexation proposal.

FISCAL IMPACT / PROJECT FINANCIAL ANALYSIS: Case # _____
Budget Line Item # _____ YTD Line Item Balance \$ _____
Estimated Hours Spent to Date: _____ Estimated Completion Date: _____
Staff Contact: _____ Phone # _____
Comments: _____

ACKNOWLEDGEMENT BY OTHER AFFECTED CITY DEPARTMENTS: (IF APPLICABLE)

- | | | |
|--|--|---|
| <input checked="" type="checkbox"/> City Administrator | <input type="checkbox"/> Library | <input type="checkbox"/> Safety Committee |
| <input checked="" type="checkbox"/> City Attorney | <input type="checkbox"/> Mayor | <input type="checkbox"/> Streets |
| <input type="checkbox"/> City Clerk | <input type="checkbox"/> Planning | <input type="checkbox"/> Treasurer |
| <input type="checkbox"/> Building | <input type="checkbox"/> Police | _____ |
| <input type="checkbox"/> Engineer | <input type="checkbox"/> Public Works, Parks | _____ |
| <input type="checkbox"/> Fire Dept. | <input type="checkbox"/> P & Z Commission | _____ |

RECOMMENDATION FROM APPLICABLE DEPARTMENT HEAD:

Review and approve the contract as presented or as amended by the Council.

ADMINISTRATIVE COMMENTS/APPROVAL:

City Administrator _____ Dept. Head Attend Meeting (circle one) Yes No

ACTION OF THE CITY COUNCIL:

Date _____

City Clerk _____

FOLLOW-UP:

*Ord./Res./Agmt./Order Originals: Record
Copies (all info.): _____
Instrument # _____

*Additional/Exceptional Originals to: _____
Copies (AIS only)

AGREEMENT FOR CONSULTING SERVICES
Quigley Annexation Analysis

THIS AGREEMENT, is made and entered into this 1st day of December , 2008, by and between Richard Caplan & Associates with offices at 7301 Mission Road, Suite 100, Prairie Village, Kansas 66208 (hereinafter "RCA") and the City of Hailey, Idaho, (hereinafter "City")

WHEREAS, CITY desires to engage RCA to perform certain services in connection with the proposed City of Hailey annexation of Quigley Canyon; and,

WHEREAS, RCA represents that it is fully qualified and willing to perform the services required hereunder,

NOW, THEREFORE, for and in consideration of the covenants and conditions set forth, the parties do mutually agree as follows:

Section I
SCOPE OF SERVICES

The major tasks for RCA services are listed below and include.

1. Benchmark Levels of Service

RCA will conduct an extensive community dialogue that includes an "Importance-Satisfaction" survey of residents. The results of this survey will enhance Hailey officials to better understand attitudes and opinions about existing and potential city amenities and areas of service the city is providing. The survey will be based on the concept that Hailey seeks to maximize overall citizen satisfaction by ranking amenities and improvements in those services where the level of satisfaction are ranked lowest and the perceived importance is highest. This survey will be supplemented with two public forums and stakeholder interviews described in the following tasks:

- A. Community Service Benchmark Survey – A survey will be prepared and disseminated that assesses Hailey resident's expectations with particular emphasis on existing facilities, services and amenities and those proposed by the Quigley development. This will be accomplished utilizing five methods:
- i. A mail back survey in the city's monthly utility billing that may be returned with the payments or dropped off at City Hall or the Hailey Library;
 - ii. Distributing and collecting the survey at the Hailey Public Library;
 - iii. Placing the survey on the city's web site;
 - iv. Holding two public forums and/or focus groups announcing the specific purpose, times and locations to solicit citizen input; and
 - v. Conducting up to 15 stakeholder interviews of city elected and appointed officials.

The survey results will be calculated and presented by summing the percentage of responses for items selected as 1st, 2nd and 3rd most important for the city to emphasize in the future. The results will provide an assessment of the city's current improvements and amenities prioritizing which amenities and related level of service Hailey residents want addressed, offered, improved and/or enhanced within current and future city boundaries. The results of the survey will be presented to the City Council, staff and made available to the public through the media and posted on the city's web site.

B. Annual Costs Analysis to Meet Benchmark

Based on the results of the survey, on-going maintenance cost estimates will be prepared that determine

the incremental annual costs associated with providing, increasing and/or offering improvements, services and/or amenities that respond to the highest ranked citizen responses.

2. Cost-Benefit Analysis

Two cost-benefit analyses will be prepared based on the proposed annexation project including:

- A. Cost Benefit Analysis of the Quigley Annexation, and
- B. Cost-Benefit Implications and Assessment of the Commission's Recommended Conditions.

This will be a comprehensive assessment of the municipal costs and benefits of the proposed development and annexed areas, including the proposed golf course and open space land uses and those services and activities generated by the proposed Quigley Canyon development on the City of Hailey. This analysis will be based on the mutually agreed upon assumptions as well as all related project materials currently under review by the city. Where key project-related assumptions are not available, RCA will prepare realistic assumptions based on the most accurate market, real estate, recreational uses and tourism industry data available.

The cost-benefit studies will analyze and calculate the fiscal impact on the City of Hailey and will include all one-time and recurring municipal revenues and the cost of city services upon build out. The impacts presented in this report will include from initiation of construction to year 20.

3. Golf Course and Nordic Skiing Cost-Benefit Analysis

A detailed analysis of the costs and benefits of the proposed golf course and Nordic skiing amenity activities generated by the Quigley Canyon annexation on city services will be performed. These analyses will be based on the proposed master development plan provided as currently approved as well as potential modifications currently under review by the city. Key assumptions offered by the applicant will be subject to independent verification. Where key assumptions are not available related to golf course operations and Nordic skiing activities, we will prepare assumptions based on prevailing Blaine County and other Idaho golfing and Nordic ski industry data.

The cost-benefit analysis will calculate and incorporate the cost of all City of Hailey services such as law enforcement, irrigation services and all related aspects associated with the proposed amenities that reflect the golfing and Nordic skiing industry. All data sources will be documented in the study.

The final report will analyze the proposed annexation's impact and will recommend a base amount for annexation fees. A discussion of the non-quantifiable costs and benefits associated with the proposed annexation will be incorporated into the final report.

Section II. COMPENSATION

CITY agrees to pay RCA the fixed sum of Twenty Four Thousand Five Hundred Dollars (\$24,500.00) for completion of the scope of services identified in Section I. Payment for services shall be made monthly in accordance with CITY policies and practices based upon work completed and upon receipt of invoices from RCA.

The costs of distributing the citizen survey in the City's utility billing will be the responsibility of the City of Hailey. RCA will be responsible for tabulation of the survey results and analyzing the findings.

Three site visits are planned and budgeted to complete these services. If more site visits are requested by the City, out-of-pocket travel expenses from RCA's office to the city will be subject to additional

reimbursement and hours required on site shall be billed and subject to reimbursement at an hourly rate of one hundred and five dollars (\$105.00).

**Section III.
TIME SCHEDULE**

RCA shall complete all services identified, except the revisions to the final reports within 90 days after execution of this agreement in accordance with the tasks in the following table.

Major Task	Dec. 1 - 15, 2008	Dec. 16 - 31, 2008	Jan. 1 - 23, 2009	Jan. 16 - 31, 2009	Feb. 1 - 14, 2009	Feb. 17 - 28, 2009
Project Kick-off; Data collection	Dec. 1					
Hailey Site Visits	Week of Dec. 8		Week of Jan. 10			Presentation(s)
I. A. Benchmark Level of Service Community Survey, Focus Groups and Public Forum	XXXXXXXXXXXXXXXX					
I. B. Costs to Meet Benchmarks			XXXX			
Tabulate & Submit Survey Results			XXXX	By Jan. 31		
PUBLIC COMMENT ON SURVEY					XXXX	
II. Cost-Benefit Analyses	XXXXXXXXXXXXXXXX					
III. Golf & Nordic Skiing Analysis	XXXXXXXXXXXXXXXX					
Submit Report					Feb. 16	
PUBLIC COMMENT ON REPORT						XXXX
Public Presentation(s)						March

**Section IV.
GENERAL PROVISIONS**

1. RESPONSIBILITY

RCA shall be responsible for the professional quality, technical accuracy and the coordination of all data, reports, documents or other services to be provided, and shall, without additional compensation, correct or revise any errors or deficiencies promptly upon notice or discovery thereof.

2. CHANGES

CITY may, in consultation with RCA, by written authorization, make changes in the scope of services. If such changes result in an increase or decrease in services, the time required for performance, or compensation, the agreement must be modified in writing by both parties. RCA shall not provide additional services or incur expenses for which additional compensation is to be charged without the expressed written authorization of CITY.

3. OWNERSHIP

All non-proprietary data, information, reports, or other documents or materials prepared by RCA shall become the property of CITY. RCA may retain a record copy for its file.

4. RELATIONSHIP

The legal relationship of RCA to CITY hereunder shall be that of an independent contractor and not that of an employee.

5. COMPLIANCE WITH LAWS

RCA shall comply with all applicable federal, state, and local laws, ordinances, rules, regulations, and orders in effect on the date of this Agreement.

6. SEVERABILITY

In the event that any term or provision of this Agreement is held to be illegal, invalid, or unenforceable under the laws, regulations, or ordinances of any federal, state, or other government to which this Agreement is subject, such term or provision shall be deemed severed from this Agreement and the remaining terms and provisions shall remain unaffected thereby and continue in full force.

7. NOTICES

Any notice required to be given under any provision of this Agreement by either party shall be transmitted to the other by personal delivery, Fedex or by U.S. mail address as follows:

CITY: City of Hailey
115 South Main Street
Hailey, ID 83333
Attn: Beth Robrahn, Planning Director

RCA: Richard Caplan & Associates (RCA)
7301 Mission Road, Suite 100
Prairie Village, KS 66208

8. MODIFICATION

This Agreement may only be modified by a written amendment, duly executed by both parties.

9. EXTENT OF AGREEMENT

This Agreement contains all of the promises, representations, and understandings of the parties and supersedes any previous understandings, commitments, proposals, or agreements, whether oral or written, and may only be modified as herein provided.

For City of Hailey, Idaho

For Richard Caplan & Associates

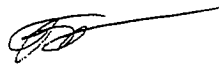
Date

December 1, 2008

Date

AGENDA ITEM SUMMARY

DATE: 12/8/08 DEPARTMENT: Public Words

DEPT. HEAD SIGNATURE: 

SUBJECT:

Contracts for Snowplowing Services

AUTHORITY: ID Code _____ IAR _____ City Ordinance/Code 5.20
(IF APPLICABLE)

BACKGROUND/SUMMARY OF ALTERNATIVES CONSIDERED:

I am enclosing two proposed contracts for services with KATCO and Sluder, who would provide both contract labor and equipment for snowplowing. The contracts are consistent with the proposals which the Council reviewed and approved in an earlier meeting.

FISCAL IMPACT / PROJECT FINANCIAL ANALYSIS:

Caselle # _____
Budget Line Item # _____ YTD Line Item Balance \$ _____
Estimated Hours Spent to Date: _____ Estimated Completion Date: _____
Staff Contact: _____ Phone # _____

ACKNOWLEDGEMENT BY OTHER AFFECTED CITY DEPARTMENTS: (IF APPLICABLE)

____ City Attorney	____ Clerk / Finance Director	____ Engineer	____ Building
____ Library	____ Planning	____ Fire Dept.	_____
____ Safety Committee	____ P & Z Commission	____ Police	_____
____ Streets	____ Public Works, Parks	____ Mayor	_____

RECOMMENDATION FROM APPLICABLE DEPARTMENT HEAD:

Make a motion to authorize the Mayor to sign the contracts with KATCO and Sluder.

ADMINISTRATIVE COMMENTS/APPROVAL:

City Administrator _____ Dept. Head Attend Meeting (circle one) Yes No

ACTION OF THE CITY COUNCIL:

Date _____
City Clerk _____

FOLLOW-UP:

*Ord./Res./Agmt./Order Originals: _____ *Additional/Exceptional Originals to: _____
Copies (all info.): _____ Copies
Instrument # _____

CONTRACT FOR SERVICES

THIS CONTRACT FOR SERVICES ("Agreement") is made this ____ day of December, 2008, by and between the City Hailey, Idaho, a body corporate and politic and a political subdivision of the State of Idaho ("City"), and Katco Excavation, an Idaho corporation ("Contractor").

RECITALS

A The City is authorized pursuant to Idaho law to enter into contracts for services including services for snowplowing.

B Subject to the terms and conditions of this Agreement, the Contractor is willing to provide snowplowing services and snowplowing equipment for the City during the winter of 2008/09.

AGREEMENT

NOW, THEREFORE, in consideration of the mutual agreements hereinafter contained and subject to the terms and conditions hereinafter stated, it is hereby understood and agreed by the parties hereto as follows:

1. TERM. This Agreement shall be effective upon execution of the Agreement and will continue in full force and effect through the 30th day of September, 2009. The term of this Agreement may be extended by the parties by agreement in writing.

2. SERVICES. Contractor agrees to employ and furnish all necessary personnel with Class A CDL to operate both City and Contractor vehicles and to furnish and maintain four (4) ten yard end dump trucks and two (2) loaders (6 ½ and 3 yards), together with necessary supplies and equipment, and such other items as are reasonably necessary to provide snow plowing services within the corporate limits of the City. The parties agree that the City shall

provide all necessary fuel for the operation of the end dump trucks and loaders for work necessary under this Agreement. The City will generally direct the Contractor to perform snowplowing services under certain conditions and at certain times and locations, to be determined by the City in its sole discretion.

3. CONSIDERATION. In consideration for the services performed by the Contractor according to the terms of this Agreement, the City shall pay Contractor \$34 per hour for each Class A CDL operator, and \$85 per hour for each end dump truck. The parties understand that \$85 per hour for an end dump truck includes the costs of the operator of the end dump truck. In addition, the City agrees to pay Contractor \$31,200 as a minimum charge for the two loaders. The \$31,200 charge is calculated at \$78 per hour for a minimum of 200 hours (2 x \$78 x 200). In the event the combined usage of the two loaders exceed 200 hours during the term of this Agreement, the City shall pay Contractor \$78 per hour for each loader. Contractor shall provide monthly invoices to the City for any charges incurred during a month and for the minimum charge for the loaders on or before the 5th day of January, 2009, and continuing on the 5th day of every month thereafter during the period of providing snowplowing services under this Agreement. The minimum charge for the loaders shall be billed by Contractor in four monthly installments of \$7,800, beginning with the first invoice provided to the City on the 5th day of January, 2009, and continuing on the 5th of day of February, March and April, 2009. The City shall pay all invoices by the last day of the month when the invoice was received.

4. INDEPENDENT CONTRACTOR. The parties acknowledge and agree that the Contractor is an independent contractor of the City, and that the personnel of the Contractor performing the services under this Agreement are employees of the Contractor only, and that the Contractor is solely responsible for the payment of wages and benefits and the coverage of

insurance, including worker's compensation. It is furthermore agreed that the City shall not be liable for compensation or indemnity to any of the employees of Contractor for injuries or sickness arising out of the performance of services under this Agreement, and Contractor hereby agrees to indemnify and hold harmless City from any such liability or claim.

5. INSURANCE REQUIREMENTS. The Contractor shall maintain in full force and effect, at its sole cost and expense, during the term of this Agreement, commercial general liability insurance for the purpose of protecting the City against liability for loss or damage, for bodily injury, property damage, personal injury, death, civil rights violations, and errors and omissions, relating to the operations of the Contractor under this Agreement. Such policy shall provide insurance against property damage in an amount not less than \$500,000.00 and bodily injury with limits of not less \$500,000.00 per person and \$1,000,000.00 total for each occurrence; provided, however, the minimum limits of insurance as set forth herein shall be automatically increased at any time the liability limits of the City are increased pursuant to the Idaho Tort Claims Act (*Idaho Code Sections 6-901 et seq.*). Such insurance shall be noncancellable except upon thirty (30) days prior written notice to the City. All of the insurance policies shall contain provisions that the insurers shall have no right of recovery or subrogation against the City, or the City's insurer with regard to the aforementioned losses or damages. The Contractor's certificates of insurance shall name the City and its officials, employees and agents as additional named insured and shall be endorsed to specify that such policies cover the liability assumed by the Contractor under this Agreement. The Contractor shall also secure and maintain at least the statutory amounts of worker's compensation, disability benefits, and unemployment insurance in accordance with the laws of the State of Idaho. Such insurance shall provide at least thirty (30) days written notice to Hailey before such policy is suspended, canceled, amended or

terminated. The Contractor shall provide evidence of acceptable insurance at limits listed above to City Clerk, City of Hailey, 115 Main Street So., Suite H, Hailey, Idaho 83333.

6. INDEMNIFICATION. The Contractor covenants and agrees to indemnify, defend and hold the City harmless from and against any and all claims, demands, causes of action, suits, losses, liabilities, damages, costs and expenses, including attorney fees, that may accrue, directly or indirectly, by reason of any act or omission on the part of the Contractor, its agents, employees, assigns or anyone subcontracting with Contractor, related to damages that arise out of the Contractor's services under this Agreement, to bodily injury, property damage, personal injury and death that arise out of the Contractor's services under this Agreement, and to the provision of any service or duty under this Agreement. Contractor shall have the duty to appear and defend any such demand, claim, suit or action on behalf of the City, without cost or expense to the City.

7. TERMINATION. Any party to this Agreement may terminate its obligations under this Agreement upon providing the other parties with thirty (30) days written notice. In the event the Agreement is terminated for cause, the City shall pay Contractor for its services incurred before the date of the service of the written notice of termination, and only the pro rata amount of the minimum payment for the loaders which would be payable at the end of the month in which the notice is delivered. In the event the Agreement is terminated without cause, the City shall pay Contractor for its services incurred before the date of the service of the written notice of termination, and the entire amount of the minimum payment for the loaders which would be due under this Agreement.

8. MISCELLANEOUS PROVISIONS.

8.1 Notices. Any notice under this Agreement shall be in writing and shall be

effective when actually delivered in person or three days after being deposited in the U.S. mail, registered or certified, postage prepaid and addressed to the party at the address stated in this Agreement or such other address as either party may designate by written notice to the other.

8.2 Waiver. The waiver by either party of the breach of any provision of this Agreement by the other party shall not operate or be construed as a waiver of any subsequent breach.

8.3 Assignment. Except as otherwise provided within this Agreement, neither party hereto may transfer or assign this Agreement without prior written consent of the other party.

8.4 Law Governing. This Agreement shall be governed by and construed in accordance with the laws of the State of Idaho.

8.5 Attorney's Fees. In the event of any dispute with regard to the interpretation or enforcement of this Agreement, the prevailing party shall be entitled to recover his/her reasonable costs and attorneys' fees incurred therein, whether or not a lawsuit is actually filed, and on any appeals, and in any bankruptcy proceeding.

8.6 Entire Agreement. This Agreement contains the entire understanding between and among the parties and supersedes any prior understandings and agreements among them respecting the subject matter of this Agreement.

8.7 Counterparts. This Agreement may be executed in several counterparts and all so executed shall constitute one Agreement, binding on all the parties hereto even though all the parties are not signatories to the original or the same counterpart.

8.8 Facsimile. Facsimile transmission of any signed original document and retransmission of any signed facsimile transmission shall be same as delivery of the original.

8.9 Remedies. The rights and remedies provided by this Agreement are cumulative and the use of any one right or remedy by any party shall not preclude nor waive its rights to use any or all other remedies. Any rights provided to the parties under this Agreement are given in addition to any other rights the parties may have by law, statute, ordinance or otherwise.

8.10 Severability. Every provision of this Agreement is intended to be severable. If any term or provision hereof is illegal or invalid for any reason whatsoever, such

illegality or invalidity shall not affect the validity of the remainder of the Agreement.

8.11 Authority. Each signatory agrees that he or she has full authority and consent to sign this Agreement.

8.12 Amendment. This Agreement may be revised, amended, or canceled in whole or in part, only by means of a written instrument executed by both parties hereto.

8.13 Interpretation. This Agreement shall be liberally construed in accordance with the general purposes of this Agreement and interpreted and enforced under the laws of the State of Idaho. No presumption shall exist in favor of or against any party to this Agreement as the result of drafting and preparing this Agreement. The headings in this Agreement are inserted for convenience and identification only and are in no way intended to describe, interpret, define or limit the scope, extent or intent of the Agreement or any provisions of the Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Contract for Services on the day and year first above written.

CITY OF HAILEY

By _____
Richard L. Davis, Mayor

ATTEST:

Mary Cone, City Clerk

KATCO EXCAVATION, INC.

By _____
Michael Evans, its President

CONTRACT FOR SERVICES

THIS CONTRACT FOR SERVICES ("Agreement") is made this ___ day of December, 2008, by and between the City Hailey, Idaho, a body corporate and politic and a political subdivision of the State of Idaho ("City"), and Sluder Construction, Inc., an Idaho corporation ("Contractor").

RECITALS

A The City is authorized pursuant to Idaho law to enter into contracts for services including services for snowplowing.

B Subject to the terms and conditions of this Agreement, the Contractor is willing to provide snowplowing services and snowplowing equipment for the City during the winter of 2008/09.

AGREEMENT

NOW, THEREFORE, in consideration of the mutual agreements hereinafter contained and subject to the terms and conditions hereinafter stated, it is hereby understood and agreed by the parties hereto as follows:

1. TERM. This Agreement shall be effective upon execution of the Agreement and will continue in full force and effect through the 30th day of September, 2009. The term of this Agreement may be extended by the parties by agreement in writing.

2. SERVICES. Contractor agrees to employ and furnish all necessary personnel with Class A CDL to operate a City owned snow blower and to furnish and maintain a D65PX low ground pressure dozer, together with necessary supplies and equipment, and such other items as are reasonably necessary to provide snow plowing services within the corporate limits of the City. The parties agree that the City shall provide all necessary fuel for the operation of

the dozer for work necessary under this Agreement. The City will generally direct the Contractor to perform snowplowing services under certain conditions and at certain times and locations, to be determined by the City in its sole discretion.

3. CONSIDERATION. In consideration for the services performed by the Contractor according to the terms of this Agreement, the City shall pay Contractor \$44 per hour for each Class A CDL operator, and \$89.50 per hour for the dozer. The parties understand that \$89.50 per hour for the dozer includes the costs of the operator of the dozer. In addition, the City agrees to pay Contractor \$11,187.50 as a minimum charge for the dozer. The \$11,187.50 charge is calculated at \$89.50 per hour for a minimum of 125 hours ($\$89.50 \times 125$). In the event the usage of the dozer exceed 125 hours during the term of this Agreement, the City shall pay Contractor \$89.50 per hour for the dozer. Contractor shall provide monthly invoices to the City for any charges incurred during a month and for the minimum charge for the dozer on or before the 5th day of January, 2009, and continuing on the 5th day of every month thereafter during the period of providing snowplowing services under this Agreement. The minimum charge for the dozer shall be billed by Contractor in four monthly installments of \$2796.88, beginning with the first invoice provided to the City on the 5th day of January, 2009, and continuing on the 5th of day of February, March and April, 2009. The City shall pay all invoices by the last day of the month when the invoice was received.

4. INDEPENDENT CONTRACTOR. The parties acknowledge and agree that the Contractor is an independent contractor of the City, and that the personnel of the Contractor performing the services under this Agreement are employees of the Contractor only, and that the Contractor is solely responsible for the payment of wages and benefits and the coverage of insurance, including worker's compensation. It is furthermore agreed that the City shall not be

liable for compensation or indemnity to any of the employees of Contractor for injuries or sickness arising out of the performance of services under this Agreement, and Contractor hereby agrees to indemnify and hold harmless City from any such liability or claim.

5. INSURANCE REQUIREMENTS. The Contractor shall maintain in full force and effect, at its sole cost and expense, during the term of this Agreement, commercial general liability insurance for the purpose of protecting the City against liability for loss or damage, for bodily injury, property damage, personal injury, death, civil rights violations, and errors and omissions, relating to the operations of the Contractor under this Agreement. Such policy shall provide insurance against property damage in an amount not less than \$500,000.00 and bodily injury with limits of not less \$500,000.00 per person and \$1,000,000.00 total for each occurrence; provided, however, the minimum limits of insurance as set forth herein shall be automatically increased at any time the liability limits of the City are increased pursuant to the Idaho Tort Claims Act (*Idaho Code Sections 6-901 et seq.*). Such insurance shall be noncancellable except upon thirty (30) days prior written notice to the City. All of the insurance policies shall contain provisions that the insurers shall have no right of recovery or subrogation against the City, or the City's insurer with regard to the aforementioned losses or damages. The Contractor's certificates of insurance shall name the City and its officials, employees and agents as additional named insured and shall be endorsed to specify that such policies cover the liability assumed by the Contractor under this Agreement. The Contractor shall also secure and maintain at least the statutory amounts of worker's compensation, disability benefits, and unemployment insurance in accordance with the laws of the State of Idaho. Such insurance shall provide at least thirty (30) days written notice to Hailey before such policy is suspended, canceled, amended or terminated. The Contractor shall provide evidence of acceptable insurance at limits listed above

to City Clerk, City of Hailey, 115 Main Street So., Suite H, Hailey, Idaho 83333.

6. INDEMNIFICATION. The Contractor covenants and agrees to indemnify, defend and hold the City harmless from and against any and all claims, demands, causes of action, suits, losses, liabilities, damages, costs and expenses, including attorney fees, that may accrue, directly or indirectly, by reason of any act or omission on the part of the Contractor, its agents, employees, assigns or anyone subcontracting with Contractor, related to damages that arise out of the Contractor's services under this Agreement, to bodily injury, property damage, personal injury and death that arise out of the Contractor's services under this Agreement, and to the provision of any service or duty under this Agreement. Contractor shall have the duty to appear and defend any such demand, claim, suit or action on behalf of the City, without cost or expense to the City.

7. TERMINATION. Any party to this Agreement may terminate its obligations under this Agreement upon providing the other parties with thirty (30) days written notice. In the event the Agreement is terminated for cause, the City shall pay Contractor for its services incurred before the date of the service of the written notice of termination, and only the pro rata amount of the minimum payment for the loaders which would be payable at the end of the month in which the notice is delivered. In the event the Agreement is terminated without cause, the City shall pay Contractor for its services incurred before the date of the service of the written notice of termination, and the entire amount of the minimum payment for the loaders which would be due under this Agreement.

8. MISCELLANEOUS PROVISIONS.

8.1 Notices. Any notice under this Agreement shall be in writing and shall be effective when actually delivered in person or three days after being deposited in the U.S. mail,

registered or certified, postage prepaid and addressed to the party at the address stated in this Agreement or such other address as either party may designate by written notice to the other.

8.2 Waiver. The waiver by either party of the breach of any provision of this Agreement by the other party shall not operate or be construed as a waiver of any subsequent breach.

8.3 Assignment. Except as otherwise provided within this Agreement, neither party hereto may transfer or assign this Agreement without prior written consent of the other party.

8.4 Law Governing. This Agreement shall be governed by and construed in accordance with the laws of the State of Idaho.

8.5 Attorney's Fees. In the event of any dispute with regard to the interpretation or enforcement of this Agreement, the prevailing party shall be entitled to recover his/her reasonable costs and attorneys' fees incurred therein, whether or not a lawsuit is actually filed, and on any appeals, and in any bankruptcy proceeding.

8.6 Entire Agreement. This Agreement contains the entire understanding between and among the parties and supersedes any prior understandings and agreements among them respecting the subject matter of this Agreement.

8.7 Counterparts. This Agreement may be executed in several counterparts and all so executed shall constitute one Agreement, binding on all the parties hereto even though all the parties are not signatories to the original or the same counterpart.

8.8 Facsimile. Facsimile transmission of any signed original document and retransmission of any signed facsimile transmission shall be same as delivery of the original.

8.9 Remedies. The rights and remedies provided by this Agreement are

cumulative and the use of any one right or remedy by any party shall not preclude nor waive its rights to use any or all other remedies. Any rights provided to the parties under this Agreement are given in addition to any other rights the parties may have by law, statute, ordinance or otherwise.

8.10 Severability. Every provision of this Agreement is intended to be severable. If any term or provision hereof is illegal or invalid for any reason whatsoever, such illegality or invalidity shall not affect the validity of the remainder of the Agreement.

8.11 Authority. Each signatory agrees that he or she has full authority and consent to sign this Agreement.

8.12 Amendment. This Agreement may be revised, amended, or canceled in whole or in part, only by means of a written instrument executed by both parties hereto.

8.13 Interpretation. This Agreement shall be liberally construed in accordance with the general purposes of this Agreement and interpreted and enforced under the laws of the State of Idaho. No presumption shall exist in favor of or against any party to this Agreement as the result of drafting and preparing this Agreement. The headings in this Agreement are inserted for convenience and identification only and are in no way intended to describe, interpret, define or limit the scope, extent or intent of the Agreement or any provisions of the Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Contract for Services on the day and year first above written.

CITY OF HAILEY

By _____
Richard L. Davis, Mayor

ATTEST:

AGENDA ITEM SUMMARY

DATE: 12/03/08 DEPARTMENT: Finance & Records DEPT. HEAD SIGNATURE: _____

SUBJECT:
Taxi License Renewals

AUTHORITY: ID Code _____ IAR _____ City Ordinance/Code 5.20
(IFAPPLICABLE)

BACKGROUND/SUMMARY OF ALTERNATIVES CONSIDERED:

Annual taxi business license renewals for the following:

Wood River Taxi
Sun Valley Chauffeur / A-Cab

City staff and Hailey Police Department have reviewed and approved applications.

FISCAL IMPACT / PROJECT FINANCIAL ANALYSIS Caselle # _____
Budget Line Item # _____ YTD Line Item Balance \$ _____
Estimated Hours Spent to Date: _____ Estimated Completion Date: _____
Staff Contact: _____ Phone # _____

ACKNOWLEDGEMENT BY OTHER AFFECTED CITY DEPARTMENTS: (IFAPPLICABLE)

___ City Attorney	___ Clerk / Finance Director	___ Engineer	___ Building
___ Library	___ Planning	___ Fire Dept.	_____
___ Safety Committee	___ P & Z Commission	___ Police	_____
___ Streets	___ Public Works, Parks	___ Mayor	_____

RECOMMENDATION FROM APPLICABLE DEPARTMENT HEAD:

Approve Wood River Taxi and Sun Valley Chauffeur / A-Cab for 2009 license.

ADMINISTRATIVE COMMENTS/APPROVAL:

City Administrator _____ Dept. Head Attend Meeting (circle one) Yes No

ACTION OF THE CITY COUNCIL:

Date _____
City Clerk _____

FOLLOW-UP:

*Ord./Res./Agmt./Order Originals: _____ *Additional/Exceptional Originals to: _____
Copies (all info.): _____ Copies
Instrument # _____

SV chauffeur

Airport Fares

	Hailey	South Mid Valley	North Mid Valley	Ketchum Elkhorn Sun Valley Warm Springs Lane Ranch Weyyakin	Adams Gulch	Choc Gulch Eagle Creek Fox Creek North Fork	BELLEVUE
1 Pax	\$13	\$22	\$25	\$25	\$27	\$30	\$15.00
2 Pax	\$18	\$33	\$40	\$40	\$41	\$45	\$25.00
3 Pax	\$23	\$44	\$52	\$52	\$55	\$60	\$35.00
4 Pax	\$28	\$55	\$64	\$64	\$69	\$75	\$45.00
5 Pax	\$33	\$66	\$76	\$76	\$83	\$90	\$55.00
6 Pax	\$38	\$77	\$88	\$88	\$97	\$105	\$65.00
7 Pax	\$42	\$88	\$100	\$100	\$111	\$120	\$75.00
8 Pax	\$48	\$99	\$112	\$112	\$125	\$135	\$85.00
9 Pax	\$53	\$110	\$124	\$124	\$139	\$150	\$95.00
10 Pax	\$58	\$121	\$136	\$136	\$153	\$165	\$105.00
11 Pax	\$63	\$132	\$148	\$148	\$167	\$180	\$115.00
12 Pax	\$68	\$143	\$160	\$160	\$181	\$195	\$125.00
13 Pax	\$73	\$154	\$172	\$172	\$195	\$210	\$135.00

Hailey Fares

	Hailey	Bellevue	S Mid Valley	N Mid Valley	Ketchum, Elkhorn, Sun Valley Warm Springs, Lane Ranch, Weyyakin
1 Pax	\$10	\$10	\$15	\$25	\$25
2 Pax	\$13	\$15	\$20	\$35	\$35
3 Pax	\$16	\$20	\$25	\$45	\$45
4 Pax	\$19	\$25	\$30	\$55	\$55
5 Pax	\$22	\$30	\$35	\$65	\$65
6 Pax	\$25	\$35	\$40	\$75	\$75
7 Pax	\$28 MAX	\$35 MAX	\$45 MAX	\$65 MAX	\$85 MAX

Ketchum Fares

	Ketchum Sun Valley Warm Springs	Hailey	Bellevue	S Mid Valley	N Mid Valley	Elkhorn Adams Gulch Lake Creek Lane Ranch Weyyakin	Choc. Gulch Eagle Creek North Fork
1 Pax	\$10	\$25	\$30	\$22	\$20	\$10	\$15
2 Pax	\$13	\$35	\$37	\$28	\$25	\$14	\$22
3 Pax	\$16	\$45	\$42	\$36	\$30	\$18	\$29
4 Pax	\$19	\$55	\$49	\$43	\$35	\$22	\$38
5 Pax	\$22	\$65	\$56	\$50	\$40	\$26	\$43
6 Pax	\$25	\$75	\$63	\$57	\$45	\$30	\$50
7 Pax	\$28 MAX	\$85 MAX	\$70 MAX	\$84 MAX	##### MAX	\$30 MAX	\$50 MAX

Out of Zone Rates

Effective Dec: 15, 2006

SV Chaudhary

	Fare	Tip 20%	Sur. 10%	Total	DWA
Hourly	\$70.00	\$14.00	\$7.00	\$91.00	Showcase gets this "Hourly" price
Affiliate Hourly	\$80.00	\$16.00	\$8.00	\$104.00	Affiliate = CLS, Savoya, Limolink, etc
"Locals" Hourly	\$55.00	\$11.00	\$5.50	\$71.50	
Twin Falls	\$220.00	\$44.00	\$22.00	\$286.00	
Boise	\$330.00	\$66.00	\$33.00	\$429.00	
Salt Lake City	\$780.00	\$156.00	\$78.00	\$1,014.00	
Galena Lodge	\$60.00	\$12.00	\$6.00	\$78.00	Can use taxi - does not have to be Sub
Galena Summit	\$80.00	\$16.00	\$8.00	\$104.00	
Smiley Creek	\$100.00	\$20.00	\$10.00	\$130.00	
Stanley	\$120.00	\$24.00	\$12.00	\$156.00	
Challis	\$300.00	\$60.00	\$30.00	\$390.00	
Salmon	\$440.00	\$88.00	\$44.00	\$572.00	
Carey	\$75.00	\$15.00	\$7.50	\$97.50	Can use taxi - does not have to be Sub
Fairfield	\$80.00	\$16.00	\$8.00	\$104.00	Can use taxi - does not have to be Sub
Gooding	\$140.00	\$28.00	\$14.00	\$182.00	Can use taxi - does not have to be Sub
Shoshone	\$95.00	\$19.00	\$9.50	\$123.50	Can use taxi - does not have to be Sub
Pocatello	\$420.00	\$84.00	\$42.00	\$546.00	
Idaho Falls	\$325.00	\$65.00	\$32.50	\$422.50	

SNRA Headqtrs

Is in the North Fork zone - charge according to that zone



AUTO TRANSPORTATION SERVICE BUSINESS LICENSE APPLICATION

RECEIVED

NOV 20 2008

LICENSE FEES:

New or Renewal \$250.00
(License application for full year Jan. 01 – Dec.31)

Fingerprint Processing \$34.00
(If applicable)

TOTAL: _____

OFFICE USE ONLY	
NEW _____	RENEWAL <input checked="" type="checkbox"/>
APPROVED <input checked="" type="checkbox"/>	DENIED _____
POLICE CHECK <input checked="" type="checkbox"/>	_____

EXPIRES ANNUALLY ON DECEMBER 31ST

Business Name: Wood River Taxi

Owner Driver's License Number FAD222BK Owner Date of Birth 12/17/74

Number of Vehicles Operated by Business 3

1. Have you within the last three (3) years: been convicted of, or received a withheld judgment, been placed on probation, forfeited a bond for failure to appear for any felony or misdemeanor charge, or have any outstanding warrants? Yes _____ No

If yes, please explain: _____

2. Have you had a similar license revoked, denied or suspended by this city or any other city of this state, or of the United States, within the past three (3) years? Yes _____ No

If yes, please explain: _____

Wood River Taxi

	Ketchum to	Ketchum, Sun Valley	\$10+2
		Warm Springs, Elkhorn/Board Ranch	\$11/13+2
		North Fork	\$16+2
		Eagle Creek	\$15+2
		Glassford Heights	\$14+2
		Lake Creek/Lake Creek Meadows	\$13/14+2
		Hulen Meadows	\$12+2
		Lane Ranch	\$10+2
		Sun Tree Hollow	\$11+2
		The Meadows	\$12+2
		Cold Springs	\$13+2
		Country Chalet	\$13+2
		Gimlet	\$14+2
		Rainbow Bend	\$15+2
		East Fork to Canyon	\$16+2
		Greenhorn	\$16+2
		Hidden Hollow	\$18+2
		Heatherlands	\$19+5
		Starweather	\$19+5
		Hailey	\$21+8
		Bellevue	\$26+5
			\$10+2
Hailey to		Hailey	\$12+2
		Bellevue	
HAP to		Hailey, Woodside, Northridge	shared private
			1 \$15 \$35
			2 \$17 \$37
		Can lower to \$13 if need to	3 \$19 \$39
			4 \$21 \$41
		Bellevue, Deer Creek, Zinc Spur, Valley Club	shared private
			1 \$17 \$37
			2 \$19 \$39
			3 \$21 \$41
			4 \$23 \$43
HAP to		Heatherlands, Starweather	shared private
			1 \$21 \$40
			2 \$23 \$41
HAP to		East Fork, Gimlet still \$24+11	3 \$25 \$42
			4 \$27 \$43
HAP to		all points past Starweather to Ketchum	1 \$25 \$44
			2 \$40 \$58
			3 \$52 \$69
			4 \$64 \$80
Twin Falls	\$180/150	Boise \$340/250	Salt Lake \$550
Extra stops	\$1 for up to 5 minutes	Waiting Time	\$1 p/ea additional min
Extra Miles	\$2 p/ea additional mile	Hourly Rate	\$79

AGENDA ITEM SUMMARY

DATE: 12/8/2008

DEPARTMENT: Legal

DEPT. HEAD SIGNATURE: 

SUBJECT:

Partial Release of Lien -- Cutters

AUTHORITY: ID Code _____ IAR _____ City Ordinance/Code _____
(IF APPLICABLE)

BACKGROUND/SUMMARY OF ALTERNATIVES CONSIDERED:

I am enclosing a proposed partial release of lien for the lots which have been sold in the Cutters Subdivision. This partial release of lien is contemplated by the Cutters Annexation Agreement.

Ned

FISCAL IMPACT / PROJECT FINANCIAL ANALYSIS: Case # _____
Budget Line Item # _____ YTD Line Item Balance \$ _____
Estimated Hours Spent to Date: _____ Estimated Completion Date: _____
Staff Contact: _____ Phone # _____
Comments:

ACKNOWLEDGEMENT BY OTHER AFFECTED CITY DEPARTMENTS: (IF APPLICABLE)

___ City Attorney	___ Clerk / Finance Director	___ Engineer	___ Building
___ Library	___ Planning	___ Fire Dept.	_____
___ Safety Committee	___ P & Z Commission	___ Police	_____
___ Streets	___ Public Works, Parks	___ Mayor	_____

RECOMMENDATION FROM APPLICABLE DEPARTMENT HEAD:

Make a motion to authorize the mayor to sign the Partial Lien Release.

FOLLOW-UP REMARKS:

PARTIAL LIEN RELEASE

The City of Hailey hereby acknowledges that any and all fees for annexation, required to be paid under paragraph 4(a) of the Annexation, Services and Development Agreement Old Cutters Planned Unit Development ("Agreement") dated April 10, 2006, recorded as Instrument No. 534733, records of the County Recorder, Blaine County, Idaho, have been paid in full. In accordance with the Agreement, the City of Hailey hereby releases any and all liens for annexation fees arising under or by virtue of the Agreement against the following lots: Lots 10 and 13 of Block 2, Lots 3 and 4 of Block 3, Lots 1, 12, 13 and 14 of Block 6, and Lots 1, 2, 8, 11, 14, 15 and 20 of Block 7 of the Old Cutter's Subdivision Plat, Hailey, Blaine County, Idaho as shown on the official plat thereof, recorded November 29, 2007, as Instrument No. 553634, records of the County Recorder, Blaine County, Idaho.

DATED this ____ day of December, 2008.

CITY OF HAILEY

Richard L. Davis, Mayor

ATTEST:

Mary Cone, City Clerk

State of Idaho }
 }ss.
County of Blaine }

On this _____ day of December, 2008, before me, a Notary Public in and for said State, personally appeared Richard L. Davis, known or identified to me to be the Mayor of the City of Hailey, who executed the foregoing instrument, and acknowledged to me that he executed the same.

IN WITNESS WHEREOF, I have hereunto set my hand and seal the day and year first above written.

Notary Public for Idaho
Residing at: _____
My commission expires: _____

STAFF REPORT

TO: Hailey City Council
FROM: Becky Stokes, Treasurer
DATE: December 3, 2008
RE: **Group Health Insurance Finalization**

Following are three agreements for our group health benefits package. As follows:

Blue Cross Of Idaho – calendar year agreement for 2009: \$500 deductible; \$30 co-pay; \$1,500 Out of Pocket. (Previous carrier Regence Blue Shield – higher premium, reduced benefits; see New Business from November 24 meeting.)

VSP Vision Plan agreement for calendar year – reinstating vision coverage, which had been dropped in 2007. Coverage also discussed in previous meeting. The savings reaped from transferring coverage to BlueCross of Idaho more than offsets this program. Employee's share is paid by the City, dependants are paid by the employee. The dependant coverage is an option regardless of BlueCross coverage.

Employer Card Services and Adoption Agreement – Debit card for employee convenience for those participating in FLEX 125 Medical Spending Accounts. The card is offered without charge to the City or to the FLEX Plan participants, to be used for co-pay, employee's share of medical expenses, prescriptions, etc. It is "pre-loaded" and administered by AW Rehn Associates, our Third Party Administrator.

The above plans will be instituted January 1, 2009.



LETTER OF RECORD

This is to certify that Corkery & Jones Benefits, Inc. dba Moloney +
(Insurance Agent) O'Neill Benefits

has been appointed as Agent of Record for the company named below, for matters relating to group accident and health care coverage. This appointment is continuous until:

- a. another agent is appointed,
- b. the above-named agent is terminated by the group, or
- c. the above-named agent no longer has a "company appointment" with Blue Cross of Idaho.

At its discretion, Blue Cross of Idaho may accept the requested change of agent and notify the prior agent of record, the group, and the newly appointed agent of record that commissions will be payable to the new agent of record on the first day of the month following receipt of confirmation of the new appointment from a duly authorized officer of the group.

Name of Group: City of Hailey

Group Number: _____

By: _____
(Authorized Signature for the Group)

(Print Name)

Title: _____

Date: _____

AGENT INFORMATION

Blue Cross Broker Number: _____

Idaho License Number: _____

Business Address: 818 W. Riverside Ave., Suite 700

City, State, Zip Code: Spokane WA 99201

Business Telephone: (509) 343-9203 or
1-800-801-4448, ext. 203

Form No. 3-302 (05/08)

APPLICATION FOR MEDIUM/LARGE EMPLOYER COVERAGE

(51 or More Employees)

This application is made by City of Hailey ("Group") to Blue Cross of Idaho Health Service, Inc., 3000 E. Pine Avenue, Meridian, Idaho 83642 or P.O. Box 7408, Boise, Idaho 83707 ("Blue Cross of Idaho") for the coverage offered by Group Policy Number _____, the terms of which are hereby approved and accepted by the Group, to take effect on the Policy Date to be specified by Blue Cross of Idaho if this application is approved.

1. Group is applying for:
- | | | |
|---|---|--|
| <input checked="" type="checkbox"/> Preferred Blue [®] PPO | <input type="checkbox"/> HSA Blue SM PPO | <input type="checkbox"/> Business Blue SM |
| <input type="checkbox"/> Access Blue SM PPO | <input type="checkbox"/> Chamber Blue SM PPO | <input type="checkbox"/> POS |
- DUAL OPTION:
- | | |
|---|---|
| <input type="checkbox"/> Preferred Blue [®] PPO/HSA Blue SM PPO | <input type="checkbox"/> Access Blue SM PPO/HSA Blue SM PPO |
| <input type="checkbox"/> Business Blue SM /HSA Blue SM PPO | <input type="checkbox"/> POS/HSA Blue SM POS |
- LIMITED BENEFIT PLAN: Essential BlueSM for Chambers

2. The Group represents that it meets the definition of a Medium/Large Employer as set forth in Group Policy Number _____.
3. The Group understands it will be the Group's responsibility to maintain 75 % of eligible employees (Eligible Persons) as Enrollees (75% minimum). At the time of this application, the Group represents that it has:

A = Total employees, including active owners 87

B = Total part-time employees and those with other employer-paid group coverage, as listed on the roster 26 — all part time or elected officials (3)

Net number of Eligible Persons (A minus B) 61

4. Unless required by state or federal law or unless agreed to in writing by Blue Cross of Idaho, the Group agrees not to offer to its employees any other hospital, medical or surgical coverage that is not provided by or through Blue Cross of Idaho, including but not limited to, coverage under a fee for service/indemnity plan, health maintenance organization or other similar program or plan, if such coverage is available to the Group from Blue Cross of Idaho. If the Group violates this provision, Blue Cross of Idaho, at its sole option and upon 30 days written notice to the Group, may recalculate the required premiums for the Group's Insureds, which the Group must thereafter timely pay to maintain coverage under this Policy. Blue Cross of Idaho reserves the right to recertify with the group, on an annual basis, that Blue Cross of Idaho is the group's sole health insurance carrier.

5. The Group agrees to make the following employer contributions toward premiums:
- 100 % per employee OR \$ _____ per employee
- 0 % per dependent \$ _____ per dependent

Employers must contribute at least 50% of the monthly premium rate for employees, and contribution toward monthly premium for dependents is recommended.

6. The probationary period to be served by new employees: 30 days (cannot exceed 365 days)
- If probationary periods vary by class of employee, please explain: COVERAGE BEGINS 1st of month after employee has received two paychecks

7. Eligibility:
- A. Employee — Full-time employee regularly working 32 (minimum of 20) or more hours per week.
- B. Dependent — Spouse and unmarried children under the age of 23 or _____.
8. If group is applying for Chamber BlueSM PPO or Essential BlueSM for Chambers, the group certifies that:
- A minimum of two (2) eligible employees are enrolled on the group policy.
 - It is a member in good standing with the local Chamber of Commerce (local Chamber is the nearest Chamber to the Group's physical address).
 - A copy of the Group's Chamber membership is attached.
 - It has not offered group or individual health insurance coverage through a specific health carrier or as part of a plan or program under Internal Revenue Code 106 (contribution by employer to accident and health plans), Section 125 (cafeteria plans) or Section 162 (trade or business expenses, except for health insurance costs and self-employed individuals) for the past twenty-four (24) months.

If selecting Essential Blue for Chambers, the Essential Blue policy provides limited benefits. Review your policy carefully.

It is agreed this application supersedes any previous Blue Cross of Idaho applications.

Name of Group: City of Hailey By: _____
 (authorized signature for the group)

Group Number: _____ By: _____
 (print name)

Date: _____ Title: _____



**GROUP QUESTIONNAIRE FOR NEW GROUPS
51 OR MORE EMPLOYEES**
(THIS FORM TO BE COMPLETED WHEN SALE IS FINAL)

Independent Producer Name: Corkery + Jones Benefits
 Premium Enclosed: \$ Enc. 2nd copy of 1/1/09 + 0/1/11 Benefits

GROUP INFORMATION:

Group Number: _____ Requested Effective Date: January 1, 2009
 Name of Person Interviewed: _____ Title: _____

Legal Name of Business: City of Hailey Telephone Number: (208) 788-4221
 Mailing Address: 115 Main St. S, Suite "H" City: Hailey State: ID Zip: 83333
 Billing Address: 115 Main St. S, Suite "H" City: Hailey State: ID Zip: 83333
 Physical Address: 115 Main St. S, Suite "H" City: Hailey State: ID Zip: 83333
(no PO box)

Tax ID Number (TIN) _____

Nature of Business: Municipality (City) NAICS Code _____

Type of Business: Sole Proprietor Partnership Corporation Other (please identify) Municipality

Is the business affiliated with any other business? Yes No If yes, who? _____

Do you file a separate or joint state tax return? Separate Joint In which state is the corporate office located? _____

Contact Information

	(Mr/Mrs/Ms) Name (please print)	Title	Email Address	Phone Number	Fax Number
Executive Contact*	<u>Heather Dawson</u>	<u>Administrator</u>	<u>heather.dawson@hailey.city.idaho.gov</u>	<u>(208) 788-4221 ext. 28</u>	<u>(208) 788-2924</u>
Management Contact			<u>heather.dawson@hailey.city.idaho.gov</u>		
Group Administrator*	<u>Berkey Stokes</u>	<u>Treasurer</u>	<u>berkey.stokes@hailey.city.idaho.gov</u>	<u>(208) 788-4221 ext. 28</u>	<u>(208) 788-2924</u>
Primary Billing Contact			<u>berkey.stokes@hailey.city.idaho.gov</u>		
Alternate Billing Contact					

* must be filled in

Current Carrier Information

Name of medical carrier: Regence Blue Shield Group number: 1500.5054
 Length of time enrolled: 20 yrs. + Date of last rate change: 1/1/2008
 Current Employer Contribution: 100 % OR \$ _____ Employee 0 % OR \$ _____ Dependent
 Current Deductible \$ 500.00 Current Copay \$ N/A Current Coinsurance \$ 80% Current Out-of-Pocket \$ 2,000 Current Pharmacy \$ 3/30% / 50%
 Do you currently have maternity benefits? Yes No If Yes, describe benefits: (Includes Deductible)
 Do you currently have dental benefits? Yes No If Yes, for how long: 30+ yrs.
 Name of dental carrier: Delta Dental Plan of Idaho
 Current medical and/or dental rates: \$ 363.00 Employee \$ 752.00 Employee & Spouse \$ 491.00 Employee & 1 Child \$ 747.00 Employee & 2+ Children \$ 1,073.00 Family 845.00 or

Program(s) Applying For

- Business BlueSM Preferred BlueSM PPO Access BlueSM PPO HSA BlueSM PPO Chamber BlueSM PPO
 Essential BlueSM for Chambers (a limited benefit plan) Basic Standard Catastrophic Dental Vision
 (If applying for Basic, Standard or Catastrophic, go directly to the COBRA administration option.)
 Dual Option (Not available for Chamber Blue or Essential Blue for Chambers)
 Business BlueSM/HSA BlueSM PPO Preferred BlueSM PPO/HSA BlueSM PPO Access BlueSM PPO/HSA BlueSM PPO

Benefit Options

Business BlueSM Program (Please check one deductible and one coinsurance, with one corresponding out-of-pocket amount, where applicable.)

Deductible	Coinsurance	Out-of-Pocket			
		80%/20%		70%/30%	50%/50%
<input type="checkbox"/> \$0* <input type="checkbox"/> \$ 750 <input type="checkbox"/> \$100 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$200 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$300 <input type="checkbox"/> \$2,000 <input checked="" type="checkbox"/> \$500 *only with 50% coinsurance	<input checked="" type="checkbox"/> 80%/20% <input type="checkbox"/> 70%/30% <input type="checkbox"/> 50%/50%	<input type="checkbox"/> \$ 500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input checked="" type="checkbox"/> \$1,500 <input type="checkbox"/> \$3,000	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000	<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$ 8,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$6,000 <input type="checkbox"/> \$12,000	
<input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000	80%/20%	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$2,000	N/A	N/A	
<input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000	100%	N/A	N/A	N/A	

Preferred Blue[®] PPO Program (Please check one deductible, one copay and one coinsurance, where applicable.)

Deductible	Copay	Coinsurance		Out-of-Pocket*	
		In-Network	Out-of-Network	In-Network	Out-of-Network
<input type="checkbox"/> \$250 <input type="checkbox"/> \$1,000 <input checked="" type="checkbox"/> \$500 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$20 <input checked="" type="checkbox"/> \$30	<input type="checkbox"/> 90% 70% <input checked="" type="checkbox"/> 80% 60% <input type="checkbox"/> 70% 50%	<input type="checkbox"/> 80% 60% <input type="checkbox"/> 70% 50%	<input type="checkbox"/> \$1,500 \$3,000	<input type="checkbox"/> \$3,000 \$5,000
<input type="checkbox"/> \$250 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$20 <input type="checkbox"/> \$30	<input type="checkbox"/> 80% 60% <input type="checkbox"/> 70% 50%	<input type="checkbox"/> 70% 50%	<input type="checkbox"/> \$3,000 \$5,000	<input type="checkbox"/> \$4,500 \$6,000
<input type="checkbox"/> \$250 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$2,000	<input type="checkbox"/> \$20 <input type="checkbox"/> \$30	<input type="checkbox"/> 90% 70% <input type="checkbox"/> 80% 60% <input type="checkbox"/> 70% 50%	<input type="checkbox"/> 80% 60% <input type="checkbox"/> 70% 50%	<input type="checkbox"/> \$1,500 \$3,000	<input type="checkbox"/> \$3,000 \$5,000
<input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$30 <input type="checkbox"/> \$40	<input type="checkbox"/> 90% 70% <input type="checkbox"/> 80% 60% <input type="checkbox"/> 70% 50%	<input type="checkbox"/> 80% 60% <input type="checkbox"/> 70% 50%	<input type="checkbox"/> \$1,500 \$3,000	<input type="checkbox"/> \$3,000 \$5,000
<input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$30 <input type="checkbox"/> \$40	<input type="checkbox"/> 90% 70% <input type="checkbox"/> 80% 60% <input type="checkbox"/> 70% 50%	<input type="checkbox"/> 70% 50%	<input type="checkbox"/> \$1,500 \$3,000	<input type="checkbox"/> \$4,500 \$6,000

*Out-of-pocket option + deductible option = annual out-of-pocket maximum

Access BlueSM PPO or Chamber BlueSM PPO

(Please check one deductible, one out-of-pocket limit, one annual maximum and one prescription drug option.)

Copayment	Deductible	Coinsurance		Out-of-Pocket Limit	Annual Maximum	Prescription Drug
		In-Network	Out-of-Network			
\$25	<input type="checkbox"/> \$ 500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000	80% 60%	<input type="checkbox"/> \$ 5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000	<input type="checkbox"/> \$100,000 <input type="checkbox"/> \$250,000	<input type="checkbox"/> None <input type="checkbox"/> \$10/\$25/\$40, with \$3,000 annual maximum <input type="checkbox"/> \$15/\$30/\$45, with \$3,000 annual maximum <input type="checkbox"/> \$5 copay for generic drugs only. Member pays 100% for brand name drugs. MAC N <input type="checkbox"/> \$250 deductible Brand Only \$10/\$30/\$50 <input type="checkbox"/> \$500 deductible Brand Only \$10/\$30/\$50 <input type="checkbox"/> \$750 deductible Brand Only \$10/\$30/\$50	

Essential BlueSM for Chambers - a limited benefit plan (Please check one deductible option and one prescription drug option.)

Copayment	Deductible	Coinsurance		Out-of-Pocket Limit (Does not include deductible)	Prescription Drug
		In-Network	Out-of-Network		
\$30	<input type="checkbox"/> \$ 500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000	80% 60%	\$ 2,000	<input type="checkbox"/> None <input type="checkbox"/> \$15/\$30/\$45 with \$3,000 annual maximum <input type="checkbox"/> \$5 copay for generic drugs only. Member pays 100% for brand name drugs. MAC N <input type="checkbox"/> \$250 deductible Brand Only \$10/\$30/\$50 <input type="checkbox"/> \$500 deductible Brand Only \$10/\$30/\$50 <input type="checkbox"/> \$750 deductible Brand Only \$10/\$30/\$50	

WellConnected (For groups of 100+ or 50+ if incentive management is purchased)

Yes No. If YES, choose one or more below:

<input type="checkbox"/> Telephonic Coaching <input type="checkbox"/> All employees <input type="checkbox"/> All employees/spouses	<input type="checkbox"/> Incentive Management <input type="checkbox"/> All employees <input type="checkbox"/> All employees/spouses	<input type="checkbox"/> Biometric Screening <input type="checkbox"/> All employees <input type="checkbox"/> All employees/spouses
---	--	---

Benefit Options (continued)

HSA/BlueSM PPO (Please check one deductible, one coinsurance and one prescription drug option.)

UMBRELLA (*The claims of all family members accumulate toward the same family deductible and out-of-pocket maximum. Benefits for all family members begin after the family deductible is met.)

Single		Family*		Coinsurance		Prescription Drugs
Deductible	Out-of-Pocket <small>(Includes deductible and coinsurance)</small>	Deductible	Out-of-Pocket <small>(Includes deductible and coinsurance)</small>	In-Network	Out-of-Network	
<input type="checkbox"/> \$1,100	\$3,000	\$ 2,200	\$ 6,000	<input type="checkbox"/> 90%	70%	Major Medical Options <input type="checkbox"/> 60% coinsurance after deductible <input type="checkbox"/> 80% coinsurance after deductible <input type="checkbox"/> 100% coinsurance after deductible <small>(\$5,000/\$10,000 deductible only)</small>
<input type="checkbox"/> \$2,000	\$4,000	\$ 4,000	\$ 8,000	<input type="checkbox"/> 80%	60%	
<input type="checkbox"/> \$3,000	\$5,000	\$ 6,000	\$10,000	<input type="checkbox"/> 100% (\$5,000/\$10,000 deductible only)		
<input type="checkbox"/> \$5,000	\$5,000	\$10,000	\$10,000			

AGGREGATE (One family member will not accumulate more than the individual deductible or out-of-pocket maximum toward the family deductible or out-of-pocket maximum. After one family member has met the individual deductible, benefits begin for that person. After the family deductible has been met, benefits begin for all family members.)

Individual and Family Deductible		Individual and Family Out-of-Pocket <small>(Includes deductible and coinsurance)</small>		Coinsurance		Prescription Drugs
				In-Network	Out-of-Network	
<input type="checkbox"/> \$3,000 / \$ 6,000		\$5,000 / \$10,000		<input type="checkbox"/> 90%	70%	Major Medical Options <input type="checkbox"/> 60% coinsurance after deductible <input type="checkbox"/> 80% coinsurance after deductible <input type="checkbox"/> 100% coinsurance after deductible <small>(\$5,000/\$10,000 deductible only)</small>
<input type="checkbox"/> \$5,000 / \$10,000		\$5,000 / \$10,000		<input type="checkbox"/> 80%	60%	
				<input type="checkbox"/> 100% (\$5,000/\$10,000 deductible only)		

Dental (Issued separately for HSA/BlueSM PPO) Integrated Non-Integrated Dual: Yes No

Yes No If YES, indicate desired program below. **Dental Carryover:** Yes No (Not available with Voluntary Dental)

Traditional Dental	Annual Maximum	Waiting Periods	Orthodontia
<input type="checkbox"/> Incentive <input type="checkbox"/> \$25 Deductible <input type="checkbox"/> \$50 Deductible Preferred Blue Dental <input type="checkbox"/> Option-I <input type="checkbox"/> Option-II <input type="checkbox"/> Option-III <input type="checkbox"/> \$25 Deductible <input type="checkbox"/> \$50 Deductible	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,250 <input type="checkbox"/> \$1,500	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> None <input type="checkbox"/> \$1,000 lifetime maximum <input type="checkbox"/> \$1,250 lifetime maximum <input type="checkbox"/> \$1,500 lifetime maximum <input type="checkbox"/> No waiting period <input type="checkbox"/> 12 month waiting period <input type="checkbox"/> 24 month waiting period

Basic Blue Dental (No choice of closed list or waiting periods) \$25 Deductible \$50 Deductible **Other**

Voluntary Dental (No choice of closed list or waiting periods) Plan A Plan B Plan C **Orthodontia** (24-month waiting period)

\$25 Deductible \$50 Deductible
 \$1,000 \$1,250 \$1,500
 None \$1,250 lifetime maximum
 \$1,000 lifetime maximum \$1,500 lifetime maximum

Prescription Drug Coverage (Not available with Access BlueSM PPO; Chamber BlueSM; Essential BlueSM for Chambers or HSA/BlueSM PPO)

None
 Option 1 - \$10 Generic/\$20 Brand Name
 Option 2 - \$10 Generic/\$20 Brand Name w/\$3000 calendar year maximum benefit payment
 Option 3 - 80%/20% coinsurance with \$3000 out-of-pocket
 Option 4 - 70%/30% coinsurance with \$3000 out-of-pocket
 Option 5 - 60%/40% coinsurance with \$3000 out-of-pocket

Option 6 - 50%/50% coinsurance with \$3000 out-of-pocket
 Option 7 - \$10/\$25/\$40, 100%
 Option 8 - \$15/\$30/\$45, 100%
 Option 9 - \$250 deductible Brand Only \$10/\$30/\$50
 Option 10 - \$500 deductible Brand Only \$10/\$30/\$50
 Option 11 - \$750 deductible Brand Only \$10/\$30/\$50

Mail Order (90-day multi-month dispensing; mail order copays match retail copays) Yes No
 Contraceptive Coverage (For groups of 100+) Yes No

Vision (VSP) (Issued separately for HSA/BlueSM PPO)

Standard	Exam + Materials	Voluntary
<input type="checkbox"/> Plan CI <input type="checkbox"/> Exam Only - VSX0 \$0 Copay <input type="checkbox"/> Plan CII <input type="checkbox"/> Exam Only - VSX1 \$10 Copay <input type="checkbox"/> Plan CIII <input type="checkbox"/> Exam Only - VSX8 \$20 Copay <input type="checkbox"/> Exam Only - VSX9 \$25 Copay	<input type="checkbox"/> VSX2 \$100 (12/12) <input type="checkbox"/> VSX5 \$100 (12/24) <input type="checkbox"/> VSX3 \$125 (12/12) <input type="checkbox"/> VSX6 \$125 (12/24) <input type="checkbox"/> VSX4 \$150 (12/12) <input type="checkbox"/> VSX7 \$150 (12/24)	<input type="checkbox"/> Plan V1 \$10/\$25 (12/12) <input type="checkbox"/> Plan V2 \$20/\$25 (12/12) <input type="checkbox"/> Plan V3 \$10/\$25 (12/24) <input type="checkbox"/> Plan V4 \$20/\$25 (12/24)

4th Quarter Carryover (Only allowed with Business Blue): Yes No **Elective Abortion** (Not available for PPO): Yes No

Supplemental Accident (Not available with Chamber BlueSM PPO; Essential BlueSM for Chambers or HSA/BlueSM PPO): Yes No (PPO has a \$300 calendar year maximum per insured. Business BlueSM has a \$500 calendar year maximum per insured).

Employee Assistance Program (EAP) with Business Psychology Associates **COBRA Administration**

Yes No If Yes, number of visits 4 Does Blue Cross bill for EAP? Yes No Administered by Blue Cross of Idaho? Yes No

Optional Life and Accidental Death and Dismemberment (Administered and underwritten by selected life insurance companies)

Yes No (If Yes, obtain LifeWise Assurance Company form)

Do you have union negotiated benefits? Yes No If Yes, next scheduled negotiation date: _____

Will this coverage be offered to employees as the sole health insurance option? Yes No

If No, what other carriers will be offered and how many employees are enrolled with each?

Carrier	No. of Employees	Carrier	No. of Employees

Is any active employee or dependent or COBRA-eligible person or dependent now pregnant? Yes No

Are you aware of any active employee or dependent or COBRA-eligible person or dependent with current health problems?

Yes No

If Yes, explain: Medical History information has been disclosed on each employee's

Describe large or unusual claims: Health Statement

Are any of your employees and/or dependents unable to perform the usual, ordinary duties of his/her occupation or normal activities due to a medical or mental condition? Yes No

Do you currently have an employee(s) who, by court order (QMCSO), must provide medical insurance for a dependent(s)?

Yes No

If Yes, please attach a copy of the court order and provide the employee's name and Social Security number and the dependent's name and address.

Employee Name: _____ Social Security #: _____ Dependent Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Custodial Parent(s): _____

Address: _____ City: _____ State: _____ Zip: _____

If Support Order:

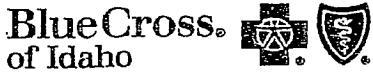
Support Agency Name: _____ Case Number: _____

Support Agency Address: _____ City: _____ State: _____ Zip: _____

We certify that the benefits outlined above are the benefits the group has agreed to purchase. (If purchasing Essential Blue for Chambers, please note that the Essential Blue policy provides limited benefits. Review your policy carefully.)

Authorized Group Representative (print name):	Title
Authorized Group Representative's Signature:	Date:
Independent Producer (print name): <u>Carkey & Jones</u>	BC #:
Independent Producer's Signature: <u>Mark for Newbed Benefits, Tom aka M. Jones & O'Skill Benefits</u>	Date: <u>11/25/2008</u>
District Manager's Signature:	Date:

Sales Representative #: _____ UW Initials: _____ Date: _____



An Independent Licensee of the Blue Cross and Blue Shield Association
 P.O. Box 7408 Boise, Idaho 83707-1408

City Of Hailey Incl. \$1K Lifetime Max TMJ Benefit

Quote Number : 16255
 Effective Date : 01/01/2009
 Broker : 003455BC
 Location : Twin Falls District Office
 Enrollment Status : Prospect

Print Date : 11/24/2008 4:56:44PM

	Option: 1	Option: 2
Medical Plan	Preferred Blue PPO	Preferred Blue PPO
Deductible	500	500
Coinsurance	80	80
Out of Pocket	1500	1500
Copayment	30	30
Maximum		
HSA Type		
Drug	\$10/\$25/\$40	\$10/\$25/\$40
Accident		
Maternity	Yes	Yes
Dual Option		
Dental Plan		
Deductible		
Maximum		
Closed List		
Waiting Period		
Orthodontia		
Vision Plan	C-1 Plan	
EAP	4 Visits	
EAP Premium	\$2.35	
COBRA Admin.	Yes	
COBRA Premium	\$1.00	
Elective Abortion		
Life		
Life Premium		
Medical Rates:		
EE	\$330.49	\$330.49
EE + SP	\$652.13	\$652.13
EE + Child	\$401.31	\$401.31
EE + Children	\$622.62	\$622.62
EE + SP + Child(ren)	\$911.80	\$911.80
Dental Rates:		
EE		
EE + SP		
EE + Child		
EE + Children		
EE + SP + Child(ren)		
Vision Rates:		
EE	\$7.20	
EE + SP	\$11.00	
EE + Child	\$11.00	
EE + Children	\$19.00	
EE + SP + Child(ren)	\$19.00	
Monthly Premium Based on Given Enrollment		
Medical	\$24,060.87	\$24,060.87
Dental		
Vision	\$538.20	
Cobra	\$59.00	
Elective Abortion		
EAP	\$138.65	
Life		
Total Premium	\$24,796.72	\$24,060.87

330.49
2.35

Quote Number : 16255
 Effective Date : 01/01/2009
 Broker : 003455BC
 Location : Twin Falls District Office
 Enrollment Status : Prospect

Print Date : 11/24/2008 4:56:44PM

Option: 2

Medical Plan

Preferred Blue PPO

Deductible 500
 Coinsurance 80
 Out of Pocket 1500
 Physician 30
 Maternity Yes
 Drug \$10/\$25/\$40

Medical	Rate	Count	Total Premium
Employee Only	330.49	48	15,202.54
Employee & Spouse	652.13	4	2,608.52
Employee & Child	401.31	1	401.31
Employee & Children	622.62	5	3,113.10
Employee, Spouse, & Children	911.80	3	2,735.40
		<u>61</u>	<u>24,060.87</u>

Authorized Group Representative _____

Authorized Independent/Agent Producer _____

EMPLOYER CARD SERVICES AND ADOPTION AGREEMENT

NAME OF EMPLOYER: CITY OF HAILEY

TAX IDENTIFICATION NUMBER (TIN): 82-6000201

ADDRESS: 115 MAIN ST. SOUTH, SUITE H / HAILEY, ID
83333

EMAIL ADDRESS: _____

PHONE NUMBER: (208) 788-4221 X

PROGRAM CONTACT: _____

EMAIL ADDRESS FOR PROGRAM CONTACT: _____

PLAN SERVICE PROVIDER: AW REMN ASSOCIATES

SIGNATURE DATE

ADOPTION AGREEMENT

By agreement, you represent and warrant that you have the authority to bind the Employer named above to all terms, conditions and obligations identified or set forth on the "TERMS AND CONDITIONS," "EXHIBIT A—PROGRAM SUMMARY" and "EXHIBIT B—FEES AND FUNDING" (collectively the "Agreement") set forth on the succeeding pages. Agreement therefore binds the Employer named above to all provisions of the Agreement. The Employer also hereby agrees (i) that it authorizes the Bank identified above to accept and pay withdrawals from time to time submitted by either the "PSP", the "Trust" or the "Third Party" (as such terms are defined herein) on the account(s) identified above; and (ii) to provide evidence to the "PSP," the "Trust" and the Third Party that such withdrawals have in fact been authorized as required hereby.

TERMS AND CONDITIONS

Your Plan Service Provider ("PSP") is offering this Program to you as a convenience to your Employees. By completing the Enrollment Form and the Adoption Agreement, you request participation in the

Program and agree to the terms and conditions of this Agreement. The representative represents and warrants that he/she has the legal authority to bind you to this Agreement. As used in this Agreement, "you" or "your" is the employer enrolling in the Program. Other terms are defined in the Glossary at the end of this Agreement.

1. **The Program.** The Program permits Employees in a Plan to use a VISA® Debit Card for payment of Qualified Expenses. Bank will issue Cards to an Employee upon enrollment by the Employee in the Program. See the Program Summary attached hereto as Exhibit A and incorporated by reference into this Agreement for detailed information concerning the operation of the Program.
2. **Fees.** All fees for the Program are set forth in Exhibit B, which is attached hereto and incorporated by reference into this Agreement and will be paid as set forth on the Adoption Agreement that you complete and submit to your PSP.
3. **Your Responsibilities.** You are responsible for the following:
 - a. **Compliance.** You are responsible for certifying that each Flex Plan Transaction is for a Qualified Expense and that the Program and each Transaction complies with the terms of the applicable Plan (Flex or HSA,), applicable law and regulations. You may delegate this responsibility to your PSP if the Plan Service Agreement between you and your PSP so states. You should consult your legal counsel concerning whether the Program complies with ERISA, the Health Insurance Portability and Accountability Act and other applicable laws and regulations. No Third Party nor the Trust nor the Custodian is responsible for any such compliance or certification.
 - b. **Funding.** You will fund the Trust Account for Flex Accounts and you and/or your Employee will fund the Custodial Account for HSAs in the manner required by your Plan Service Agreement so that the Required Balance is continuously maintained in the Trust Account and all your contributions and those of your Employee(s) to the respective HSAs are placed in the Custodial Account(s). Depending on the terms of your Plan Service Agreement, this may require deposit (or automatic withdrawal) from your account directly to the Trust, the Custodian or to your PSP for deposit to the Trust and/or the Custodian. The Required Balance may be changed on not less than five days prior notice to you. You authorize (i) your PSP to make deposits on your behalf into the Trust and/or on behalf of your employees to the Custodian and (ii) the Trustees to hold the Required Balance in the Trust Account and you and/or your Employee(s) authorize the Trustee or the Custodian to use the funds in the Trust Account and/or the Custodial Account to pay for Transactions. As set forth in your Plan Service Agreement, you authorize your PSP and/or the Trustee(s) and/or a Third Party to withdraw funds from your account(s) identified on the Enrollment Form and Adoption Agreement from time to time to pay Qualified Expenses under the Flex Plan, settle VISA® card transactions and maintain the Required Balance in the Trust at all times. All funds in the Flex Accounts are owned by you and not by any Employee. All funds in an HSA are owned by the Employee and are non-forfeitable to you regardless of whether the Employee leaves your employ. Your obligations to (i) make payment for all Flex Plan Transactions and (ii) to make available to your PSP for deposit all HSA contributions into the Custodial Account are absolute and unconditional and not subject to offset, counterclaims or other defense. If you do

not make all payments required hereunder as and when due, then in addition to owing the amount due, you agree to compensate the party making the payment or carrying any unfunded amounts at a rate equal to prime plus three percent (3%) at the Bank, adjusted monthly.

- c. **Reimbursement of Plan for Certain Flex Plan Transactions.** In the event a Card is used in a Flex Plan Transaction for the payment of expenses that are not Qualified Expenses, the Plan must be reimbursed for such Transaction. As required by applicable law you must cooperate with your PSP and all Third Parties to seek reimbursement from the Employee in such event and if the Employee fails to provide reimbursement, to the extent authorized by applicable law, you must seek to recover the amount of the Transaction through payroll deduction. If the claim remains outstanding, you may offset the amount thereof against any future payments due from the Plan. If this method of collection is not successful, you must treat the amount due as you would any other business indebtedness. If the Employee does not reimburse the Plan, you are responsible for reimbursement of the Plan for any Flex Plan Transactions that are not incurred for Qualified Expenses.
 - d. **Notification.** You must notify your PSP and/or issuing bank immediately if you discover that a Card is lost or stolen or if you are told or suspect that a Card has been used fraudulently. If you do not, you will be responsible for all charges incurred using the lost or stolen Card or further fraudulent use. You must notify your PSP immediately when an Employee ceases to be employed by you and must obtain all Cards from Employees when they cease to be employed by you. If you do not, you will be responsible for any use of the Employee's Card which occurs following termination of the Employee's employment. You must also immediately notify PSP and/or Bank immediately, of any data entry errors of which you become aware, any new accounts and any new employees.
 - e. **Data.** You shall maintain adequate records relating to operations under the Program for purposes of data backup and reconstruction. Such record shall be maintained for at least twenty (20) days following the date of the event or occurrence being recorded. You shall assume all responsibility for any losses associated with the failure to maintain data backup as required hereby.
4. **Your Representations and Warranties.** You represent and warrant that as of the date of this Agreement and as of each date that a Transaction occurs:
- a. The person submitting this Agreement on your behalf has full power and authority to bind you to the terms of this Agreement, to complete the Enrollment Form and to enroll you in the Program.
 - b. You sponsor a Flex Plan and/or make available to your Employees a voluntary HSA Plan and the Plan(s) is in compliance with all applicable Internal Revenue Service, Department of Labor and other regulations and rulings, including without limitation, requirements related to the use of debit or stored value cards.
 - c. You have a Plan Service Agreement with your PSP that complies with all applicable Internal Revenue Service regulations and rulings, including without limitation, requirements related to the use of debit or stored value cards.

- d. No contractual obligations exist that would prevent you from entering into and performing this Agreement.
 - e. Each person who enrolls in the Program as an Employee is employed by you and is a participant in a Plan from the time of the Employee's enrollment until you notify your PSP that the person's employment has been terminated.
 - f. If you offer an HSA Plan, you also offer a high deductible health plan (HDHP) for your Employees and you also insure they are otherwise eligible to participate in the HSA Plan, and the HSA Plan and the HDHP comply in all respects with the requirements of Section 223 of the Internal Revenue Code.
 - g. If you maintain an HSA Plan, Employees eligible to participate therein are not also covered by any health plan that is not an HDHP and are not entitled to benefits under Medicare, and, with respect to "catch up contributions" are over the age of eligibility therefore.
5. **Unauthorized Use of Cards.** Depending on the Plan Service Provider Agreement between you and your PSP, as between you and your PSP, your PSP shall be responsible for any unauthorized use of a Card and will reimburse the Trust or the Custodial Account for such unauthorized use unless (i) the Employee to whom the Card was issued did not report the Card as lost, stolen or used without the Employee's authorization within thirty (30) days after information concerning the unauthorized use of the Card is available to the Employee on the Program Website or by telephone or electronic mail, or (ii) you become aware that a Card has been lost or stolen or that it may have been used for unauthorized purposes and fail to immediately notify your PSP as required in Section 3d above, or (iii) you fail to immediately notify your PSP and obtain return of the Card as required in Section 3d above when an Employee terminates employment or otherwise ceases to be eligible for use of the Card. In the event the Employee fails to report as set forth in (i), above, (a) the Employee shall be responsible for reimbursing the Trust for the unauthorized use under a Flex Plan; and (b) unless you agree with the Employee to the contrary, the Employee will be responsible for reimbursing the Custodial Account for unauthorized use up to the maximum extent permitted by applicable law. In the event that you fail to report to your PSP as set forth in (ii) or fail to report to your PSP and obtain return of the Card, as set forth in (iii), above, you will be responsible for reimbursing the Trust or the Custodial Account for unauthorized use of the Card and other damages occurred from failure to make such notification and take such action.
6. **Suspension/Cancellation of Cards.** Cards may be suspended or cancelled at any time in the discretion of Bank, your PSP or a Third Party.
7. **Intellectual Property.** You may not use the marks, names, slogans, logos or designations relating to the Program without obtaining prior written consent from the owner of such intellectual property; provided, however, you may use unaltered materials and brochures to describe the Program as provided by your PSP to you without prior written consent. Upon termination of this Agreement, you must immediately discontinue all use of any materials provided by PSP to you in connection with the Program.

8. **Limitation of Liability; Maximum Damages; Related Matters.** EXCEPT AS EXPRESSLY SET FORTH IN THIS AGREEMENT, NEITHER YOUR PSP NOR ANY OTHER PERSON OR ENTITY MAKES ANY REPRESENTATIONS, WARRANTIES OR GUARANTEES OF ANY TYPE AS TO ITS SERVICES, THE PROGRAM OR CARD TRANSACTIONS. PSP DISCLAIMS ANY IMPLIED WARRANTY OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE (REGARDLESS OF WHETHER PSP HAS BEEN ADVISED OF OR HAS ANY REASON TO KNOW OF SUCH PURPOSE AND ANY AND ALL OTHER WARRANTIES, EXPRESS OR IMPLIED, WRITTEN OR ORAL). IN NO EVENT SHALL YOUR PSP OR ANY THIRD PARTY BE LIABLE FOR LOSS OF GOODWILL OR FOR SPECIAL, INDIRECT, CONSEQUENTIAL OR INCIDENTAL DAMAGES ARISING FROM YOUR PARTICIPATION IN THE PROGRAM OR FROM THE PARTICIPATION OF ANY EMPLOYEE IN THE PROGRAM. PSP SPECIFICALLY DISCLAIMS ANY LIABILITY TO ANY PERSON OR ENTITY OTHER THAN YOU UNDER THIS AGREEMENT. Unless otherwise provided in an Exhibit and regardless of the nature of the claim, whether tort, contract or otherwise, no claim or cause of action may be asserted against PSP or any Third Party more than one (1) year after such claim has been lawfully asserted against or become known to you, whichever is earlier. PSP's liability for any breach of this Agreement shall be limited to liquidated damages in the amount of the fees paid by you or the Employees to PSP under this Agreement calculated as follows: fees for the most recent three calendar months immediately preceding the month in which the event occurred that gave rise to the damages, multiplied by two. The provisions of this paragraph apply even though the loss or damage, irrespective of cause or origin, results, directly or indirectly, either from performance or nonperformance of obligations imposed by this Agreement. In no event shall any Third Party be liable to you under this Agreement unless such liability is specifically assumed by the Third Party in writing.
9. **Term.** This Agreement shall be effective on the date of this agreement and shall remain in effect for one year (the "Initial Term"). Unless either party notifies the other ninety (90) days prior to the expiration of the term or any renewal term, the term of this Agreement shall be automatically extended for additional one year terms.
10. **Termination.** After the expiration of the Initial Term, this Agreement may be terminated by either party notifying the other party in writing at least ninety (90) days prior to the date the Agreement shall terminate. If you or your PSP gives notice of termination of this Agreement, you agree to notify all Employees of the termination of the Program at least 30 days prior to termination and shall provide proof of such notification to your PSP. Either party may also terminate this Agreement in its entirety, or take such other action set forth below, reserving all rights and remedies provided in this Agreement, upon the following circumstances:
- a. **Default.** For purposes of this subsection, an "Event of Default" shall occur in the event that any party materially defaults in the performance of any of its material duties or obligations under this Agreement or if any representation or warranty of such party is not true and correct. Upon the occurrence of an Event of Default, the non-defaulting party may terminate this Agreement by giving forty-five (45) days prior written notice to the defaulting party of the non-defaulting party's intention to terminate and specifying the grounds therefor. If the defaulting party corrects the condition which constituted the Event of Default to the reasonable satisfaction of the party giving notice of termination within fifteen (15) days after receiving notice, this Agreement shall not terminate but remain in effect. If such Event of Default is not cured within such fifteen (15) day period, you shall immediately notify Employees of the termination of the Program and provide proof thereof to your PSP.

Notwithstanding the foregoing, the requirement of providing prior written notice of and an opportunity to cure shall not apply to any Event of Default related to your failure to perform your obligation to pay fees, to fund all Transactions or to maintain the Required Balance.

- b. **Insolvency.** Either party may terminate this Agreement in its entirety in the event of any filing of a petition in bankruptcy or for reorganization or debt consolidation under the federal bankruptcy laws by or against the other party, or the appointment of any receiver or conservator under any law by or against the other party, or upon the other party's making of an assignment of its assets for the benefit of creditors, or upon the application for the appointment of a receiver or trustee for the other party.
- c. **Illegality.** Either party may terminate the Agreement upon thirty (30) days advance notice upon any change in law or regulation (or any interpretation thereof or any regulatory guideline) that would render such party's continued participation illegal or in violation of any law, regulation or guideline applicable to it; provided, however, that shorter notice may be given if legally required in order to comply with such law, regulation or guideline.
- d. **Suspension of Cards.** If you do not pay fees or maintain the Required Balance, your PSP or a Third Party may, at its option, immediately suspend the use of all Cards issued to your Employees.
- e. PSP may terminate this Agreement and all obligations hereunder on such notice as is reasonable if any agreement between PSP and any Third Party, the Bank or other person or entity, which agreement is reasonably necessary for continued operation of the Program is terminated, regardless of the reason for such termination.

11. **Rights and Obligations upon Termination.** Termination of this Agreement shall not terminate, affect or impair any rights, obligations or liabilities of any party which accrue prior to termination or with respect to any transactions involving the Program occurring or arising prior to termination, or which, under this Agreement or the Exhibits, continue after termination. The provisions set forth in this Section and in Sections 3, 4, 5, 7, 8 and 15 shall survive any termination. Upon termination of this Agreement for any reason, you must (i) retrieve and return to your PSP all Cards issued to Employees in connection with the Program; and (ii) maintain any Required Balance for at least 180 days following the termination; and (iii) pay to PSP all out-of-pocket costs and expenses incurred by PSP as a result of termination, including without limitation, costs to provide files to any new Card provider, deconversion fees of Bank's external card processor associated with systematic account transfers to a new card processor, payment for Transactions which are approved in the first 180 days following termination, notwithstanding the termination of this Agreement, whether as Stand-In Transactions or Under Floor Limit Transactions or for any other reason, reimbursement of the costs for the listing of Cards or accounts on lists or data banks in order to prevent the use of such Cards or accounts after termination of this Agreement, reimbursement for Bank's external card processor's account maintenance fees through expiration of the Cards, costs incurred in providing copies of sales tickets and special handling of Cards or accounts.

12. **Indemnity.** You shall indemnify, defend and hold PSP and all Third Parties harmless from and against any and all liability, cost, expense (including reasonable attorneys fees), judgments, amounts paid in settlement and other amounts incurred by PSP or such Third Party ("Damages") due directly or indirectly to your acts or omissions, or based directly or indirectly on the

performance of services by PSP in compliance with the terms hereof or in compliance with your instructions or directions.

13. **Entire Agreement; Amendment.** This Agreement constitutes your complete and exclusive agreement with respect to the Program. Modifications of this Agreement must be in writing and signed by duly authorized representatives of the parties; provided, however, that the terms of this Agreement may be amended from time to time. Each party acknowledges that it has not entered into this Agreement in reliance upon any representation made by the other party not embodied herein.
14. **Force Majeure.** Neither party shall have any liability if it is unable to provide the Program or perform hereunder by reason of a malfunction of a third party upon which such nonperforming party relies for the Program, including but not limited to a malfunction of the VISA® authorization system, any automated clearing house, or any payment clearing organization or association, or if such party is unable to perform, in whole or in part, as a consequence of an act of God, fire, explosion, public utility failure, accident, strikes, floods, embargo, war, terrorism, nuclear disaster, riot, failure of communication links or facilities, computer malfunction of a computer operated by or on behalf of such party or other person or entity not within the control of such party, or other circumstances beyond such party's control.
15. **Role of Parties.** Your PSP may provide some or all of the Program through a Third Party. Nothing contained in this Agreement may be construed as creating or evidencing a contractual relationship between you and any Third Party. Your PSP and any Third Party are acting at all times independently of you and your Plan and are not acting as your agent or employee or engaging in a joint venture or partnership with you.
16. **Arbitration.** All disputes or differences which may arise under or in connection with this Agreement, whether arising before or after termination of this Agreement, shall be submitted to the American Arbitration Association under and in accordance with its then prevailing commercial arbitration rules. The arbitrators shall be 3 disinterested individuals having knowledge of the legal, corporate management or insurance issues relevant to the matters in dispute. Each party shall select one arbitrator and the two appointed arbitrators shall select the third. All arbitrations shall be held in Johnson County, Kansas. The written decision of the arbitrators shall be provided to both parties and shall be binding on them to the maximum extent permitted by law. Each party shall bear its own expenses of the arbitration. The arbitrators' award shall not include costs or attorneys' fees or other costs.
17. **Assignment.** You may not assign any right or interest or any obligations under this Agreement without the prior written consent of your PSP, which consent will not be unreasonably withheld, conditioned or delayed. Any attempted assignment in contravention of the above provision shall be void and ineffective. PSP may assign this Agreement and delegate the duties hereunder to a successor PSP which agrees in writing to perform all the duties of PSP hereunder; or in connection with a merger, reorganization or sale of substantially all the stock or assets of PSP.
18. **Miscellaneous.** The failure of any party to enforce at any time any provision of this Agreement will not be construed as a waiver of such provision or of the right of any party hereafter to enforce any subsequent breach of such provision. For the purposes of this Agreement, the term "person" means any individual, corporation, limited liability company, partnership, joint venture, trust, unincorporated organization or government or any agency or political subdivision thereof. This Agreement will be enforced and construed in accordance with the laws of the State of Kansas.

GLOSSARY

1. Adoption Agreement. The Employer Card Service Agreement, including these Terms and Conditions, Program Summary, and Fees and Funding Exhibits.
2. Bank. The bank issuing the Cards.
3. Card. The card which is issued to Employees and which is presented to an Eligible VISA® merchant as payment for Qualified Expenses.
4. Cardholder Agreement. The Cardholder Agreement entered into between Bank and each Employee who is issued a Card.
5. Custodian. HSA Bank, a division of Webster Bank, n.a., as the custodian of the health savings accounts for your Employees.
6. Custodial Account. The account at the Custodian into which you shall deposit, or make available to your PSP for deposit, all contributions by you and/or your Employee(s) for HSAs. Custodian shall then segregate such deposits, as required, into individual HSAs for your Employees. Your PSP or a Third Party will notify you of the name of the Bank and other relevant information regarding the Custodial Account.
7. Eligible VISA® Merchant. A merchant authorized to accept the Card for goods or services, including goods and services that are Qualified Expenses.
8. Employee. An employee who participates in a Plan.
9. Enrollment Form. The online form you complete and submit that reflects the options you choose for implementation of the Program.
10. ERISA. The Employee Retirement Income Security Act of 1974 (Public Law 93-406), as amended.
11. Flex Accounts. Subaccounts, the funds in which are at all times owned by the Employer, which are administratively maintained for Employees who have enrolled in a Plan for payment of Qualified Expenses and which reflect the Employee's participation in the applicable Plan or Plans.
12. Flex Plan. The flexible benefit plan sponsored by you for your Employees.
13. HSA Plan. The plan established by you involving deposit accounts (HSAs) established at the Custodian in connection with high deductible health plans into which you or your Employee makes contributions to pay for Qualified Expenses. The HSA may or may not be under a section 125 plan.
14. Plan. A plan sponsored by you, including but not limited to plans allowed by Internal Revenue Code Section 125 Cafeteria Plans, Section 129 Adult Child Care Accounts, Section 137 Adoption Assistance Accounts, Section 105 Health Reimbursement Arrangements, and/or Section 132 Qualified Transportation Plans, and Health Savings Account arrangements pursuant to Section 223 of the Internal Revenue Code.

15. Plan Administrator. The person or other party identified in your Plan documents that has the authority and responsibility to manage and direct the operation and administration of your Plan.
16. Plan Service Agreement. The agreement between you and your PSP pursuant to which the PSP provides services for your Plan(s).
17. Program. The Card program obtained through your PSP pursuant to which Employees may access funds in the Flex Accounts or HSA's by use of a Card at Eligible VISA® Merchants for payment of Qualified Expenses.
18. Program Summary. The summary of the Program attached hereto as Exhibit A.
19. Program Websites. Internet websites which provide services relating to the Program for you and for Employees.
20. PSP. The Plan service provider designated on this website.
21. Qualified Expenses. Expenses which are eligible for payment or reimbursement to the Employee under the Flex or the HSA Plan, as the case may be.
22. Required Balance. The balance required to be maintained on your behalf in the Trust Account from time to time for settlement of Transactions. Your PSP will notify you of the current Required Balance and of any charges thereto.
23. Stand-In Transaction. A transaction deemed authorized for payment through the VISA® system at a time when actual authorization is not possible due to system communications problems, or other reasons.
24. Third Party. A third party who provides services to you or your PSP in reliance on this Agreement, including Bank, MHM Resources LLC and the Trust.
25. Transaction. Card transactions which access Flex Account(s) or HSAs pursuant to the Cardholder Agreement.
26. Trust. The National Flex Trust which holds your Required Balance and other funds provided by Plan service providers and other employers pursuant to its terms.
27. Trust Account. All money and property of every kind and character, including principal and income, held by the Trustees under the Trust.
28. Trustees. The trustees of the Trust.

Exhibit A

PROGRAM SUMMARY

1. **General.** Your Plan(s) (a) permit you to set aside certain pretax amounts into Flex Accounts for each Employee, and (b) permit you or your Employees to set aside certain pretax amounts into HSAs. Funds in the Flex Accounts are owned by you and are used to pay for or to reimburse an Employee for the payment of Qualified Expenses. Funds in the HSAs are owned by the Employee and are used to pay for or to reimburse an Employee for the payment of Qualified Expenses. By participating in the Program, a participating Employee can pay for Qualified Expense by using a Card rather than first submitting receipts and waiting for reimbursement. Each Transaction, using a Card will be paid if authorized through the VISA® authorization system.
2. **Issuance of Cards.** Your Employees will either request a Card, or, if you choose to issue Cards to all Employees, a Card will be issued to each Employee that enrolls in the Flex Plan or the HSA Plan and his/her spouse. Each Card will be accompanied by and subject to a Cardholder Agreement between Bank and the Cardholder. Notwithstanding your issuance of the Card to an Employee, the Employee must affirmatively elect to activate the Card before use.
3. **Authorization for Transactions.** Each time a Card is used, the Transaction is sorted into a Flex Account and/or an HSA based on information about the type of VISA® Merchant that accepted the Card. The Card can be used only at certain types of merchants, as provided in IRS Revenue Ruling 2003-43, as amended from time to time or as otherwise authorized by you. An "authorization" through the VISA® system is required for processing of most Transactions. When an authorization is required, the authorization will be granted for a proposed Transaction only if there are funds available to the Employee in the Flex Account and/or the HSA being accessed. Authorization may be denied if the Transaction amount exceeds available funds in the applicable Flex Account and/or HSA, if Bank or your PSP believes that the proposed Flex Account Transaction is not for a Qualified Expense, or if the Transaction limits for a single Transaction or for outstanding Transactions are exceeded. Transaction limits are established from time to time and implemented by Bank for security purposes.
4. **Funding of Transactions.** Each day, Bank will settle for all Transactions through the VISA® system. The Trust will reimburse the Bank for the settled Flex Plan Transactions each day. Settled Transactions initiated by your Employees will be deducted that day from the balances that have been deposited on your behalf in the Trust Account or, with respect to an HSA, on behalf of your Employees in the Custodial Account. You must maintain the Required Balance in the Trust Account. As a result, you must reimburse the Trust Account in the amount of settled Flex Plan Transactions initiated by your Employees. The method of reimbursement should be included in your Plan Service Agreement. Your obligations (i) to reimburse the Trust in the amount of settled Flex Plan Transactions and to maintain the Required Balance in the Trust, and (ii) to make available to your PSP or Custodian for deposit all HSA contributions (by you and/or your Employees) to the Custodial Account are absolute, unconditional and not subject to offset or defense of any kind. If for any reason you or your PSP do not maintain the required balance in the Trust Account or fail to reimburse the Trust in the amount of all settled Flex Plan Transactions, then the Trust or a Third Party may withdraw amounts from any Flex Account identified in the Enrollment and Adoption Agreement and Terms and Conditions.

5. **Review of Expenses.** The Card may only be used for the payment of Qualified Expenses and all Transactions are subject to review. Some Transactions will be reviewed and adjudicated automatically: for example, Transactions equal to the Employee's office visit co-pay amount generated by a merchant which is a medical practice will be automatically adjudicated, and no further verification will be required. A communication (e-mail or postal mail) will be sent to each Employee no less often than monthly which will direct the Employee to the Website which includes a statement showing all of the Employee's Transactions. The Employee will be requested to review all receipts and, regarding the Flex Plan, reimburse you for use of the Card for any amounts that were not for Qualified Expenses. The Employee will be directed to supply receipts for all remaining Transactions that were not adjudicated automatically. You are responsible for the review of all Flex Plan Transactions to determine if each Transaction was for Qualified Expenses. If not, or if the Employee does not supply suitable receipts, the Employee must reimburse you for the amount of the Transaction as set forth in Section 3(c) of the Agreement and Section 6 of this Summary. For HSAs, you are not required to review the Transaction, and you are not required to seek reimbursement from the Employee for Transactions which were not for Qualified Expenses, provided, however, the Employee may be liable for penalties to the Internal Revenue Service with respect to such Transactions.

6. **Reimbursement for Non-Qualified Expenses for Flex Plan Transactions.** At the time of each Employee's enrollment in the Program and in the Cardholder Agreement, the Employee agrees to reimburse you for the amount of any Flex Plan Transaction that was not for a Qualified Expense. You are obligated to review Flex Plan Transactions and to determine whether all Flex Plan Transactions were for Qualified Expenses. For Flex Plan Transactions determined by the Employee, Employer or PSP to be for non-qualified expense ("NQE"), the Employee will automatically be notified of a balance due on the Program Website and will be sent a communication (email or postal mail) informing him or her of the amount due. There is a fee payable to a Third Party for each such NQE transaction. If the Employee does not repay you, you will be responsible for repayment to the Trust. You may, to the extent allowed by applicable law, withhold the amount at issue from the Employee's pay or may bill the Employee. However, you are responsible for determining whether applicable law will permit you to withhold such amounts and should consult legal counsel concerning such withholding. If the claim still remains outstanding, you must offset the amount thereof against future claims under the Plan. You must also take action to ensure that further violations do not occur, including denial of access to the Card. In the event the amount cannot be collected from the Employee, you must nevertheless pay such amount to the Trust and treat the amount due as you would any other business indebtedness. Consult your tax advisor on how to handle uncollectible accounts. Generally, you should include the amount due as income on the Employee's W-2 form for the year in which you have exhausted collection efforts and have determined the amount to be uncollectible.

7. **Voluntary Reimbursement for Non-Qualified Expenses for HSA Transactions.** For HSAs, you do not have the obligation to collect from Employees the amount of NQE distributions, but the Employee(s) may be subject to penalties and interest to the Internal Revenue Service with respect to HSA Transactions which were not for Qualified Expenses.

Exhibit B

Fees and Funding

Annual Card Fee

An Annual Card Fee of \$ 0 per enrolled Employee will be charged at the beginning of the plan year. This fee includes a Card for the enrolled Employee and a second card for a spouse or other dependent, if applicable.

At your option, you may either choose to have Employees pay the annual card fee or you may pay the annual fees on behalf of your Employees. There is no rebate or return of any portion of the fee upon termination of an Employee's employment or termination of the Agreement.

When Employees request and pay for the Card, fees paid by Employees will be deducted from the Employee's Flex Account.

When you choose to issue Cards to all Employees, you will pay for all Cards (regardless of whether the Card is activated or used).

Additional Card Fees

The fee for extra Cards is \$ 0. Additional Cards are available for qualified dependents or as replacements for lost Cards. Extra Cards can be ordered and paid for by Employees at the Program Website. Fees for additional Cards will be deducted from the applicable Employee's Flex Account or HSA Account.

Service Charges for Transactions that are NOT Qualified

When the Card is used pursuant to a Flex Plan to pay for items that are Not Qualified Expenses ("NQE"), the IRS requires repayment from the Employee.

A transaction is considered a NQETM when either: (1) the Plan Service Provider, Employer or Employee determines that a portion of a Card Transaction is not a Qualified Expense or (2) the Employee does not respond to a request for "receipt verification" by the requested date.

The Service Charge for each Flex or HSA Transaction that contains a NQETM will be \$ 0. The Service Charge will be added to each Flex Transaction containing a NQETM. This Service Charge will defray the cost of handling each NQETM transaction.

The Service Charge for NQETM Transactions under the Flex Plan will be paid from an Employee's Flex or HSA Account if the balance therein is sufficient. If not, the amount of the Service Charge will be added to the NQETM balance. Payment of NQETM Service Charges may be remitted through the Program Website, from the Employee's personal checking or savings account or by personal credit card. The Program Website will be used for "e-check" and credit card remittances.

If the Employee does not repay an amount due under a Flex Plan (NQETM plus related Service Charge) by the requested deadline, the Card will be suspended and the amount due will be collected from the Employer. The IRS requires that this debt be collected by the Employer from the Employee as set forth in Section 3(c) of the Terms and Conditions and Section 6 of the Program Summary and, in general, handled like any other indebtedness between an Employer and its Employee. The Employer may request the PSP to reinstate the Card when the indebtedness is resolved.

Minimum Balance

Your PSP, the Trustee(s) or a Third Party may require you to maintain a minimum balance in the Trust (the "Required Balance"). The Required Balance will typically be based on a percentage of your Employees total annual elections under the Flex Plan. Your PSP and/or the Trustee(s) or Third Party may make withdrawals from your account identified in the Enrollment and Adoption Agreement to satisfy daily settlement or Required Balance and Settlement Failure Fee (as defined below) obligations. You agree to execute any documentation necessary to authorize your PSP, the Trustee(s) and the Third Party to make such withdrawals from time to time. The Required Balance may be changed from time to time by your PSP, Bank or a Third Party, on not less than five days prior notice. If the Trust is unable to transfer sufficient funds from the designated accounts to settle the days settlement funding needs and/or to maintain the Required Balance, a settlement funding failure fee in the amount of the greater of \$250, or 10% of that day's settlement amount (the Settlement Failure Fee) will be charged to you. In addition, all Cards issued to your Employees may be suspended until sufficient funds are in the Trust to meet the Required Balance and all Settlement Failure Fees then due.

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APPLICATION FOR VISION CARE PLAN (sm)



P.O. Box 997100 • Sacramento • California 95899-7100

(800) 852-7600

Attn: Sales

Complete all applicable questions accurately and in detail.

CLIENT INFORMATION

¹ Full legal name of client as it appears on the policy: CITY OF HAILEY

Address: 115 MAIN ST. SOUTH "H"

City: HAILEY County: BLAINE State: ID ZIP: 83333

Phone: 2081788-4221 Fax: 2081788-2924 E-mail:

Principal Contact: Title:

Phone: Fax: E-mail:

Client is headquartered in state of _____ (if different from above)

² Who should we contact with payment questions?

Name: Title:

Phone: Fax: E-mail:

³ Who should we contact with eligibility questions?

Name: Title:

Phone: Fax: E-mail:

⁴ Who is the Benefit Administrator responsible for the overall administration of the plan (if not principal contact)?

Name: Title:

Phone: Fax: E-mail:

If multiple benefits administrators are at other locations, attach list of names, addresses, phone, and fax numbers.

⁵ Standard Industry Code (SIC): Division: Major Group:

What is the nature of your business? MUNICIPALITY

⁶ Membership updates will be made via a secure Internet site. Do you have Internet access? yes no

Membership information will be sent to VSP on [] (date).

Employers without Internet access for making membership updates will be contacted by VSP to review other options.

⁷ Names of separate divisions that will be covered by this plan: N/A

Will a separate billing be needed for the above divisions? yes no

Billing address (if applicable):

Firm/Organization:

Address:

City: County: State: ZIP:

Phone: Fax: E-mail:

If Self-Funded Program, do claims billings and administrative fee billings go to the same person? yes no

If no, please supply contact, title, address, phone, and fax number for each type of billing.

⁸ Send employee benefit information* to (select one):

Client's Benefit Administrator Third Party Administrator Broker/Consultant Other -please specify:

* Any non-VSP-created information outlining coverage or plan details must be reviewed by VSP prior to distribution to members.

9 Number of employees eligible for benefits: 61
Does this represent the total number of employees in the company? yes no total number: 87 (26 PART TIME)

7

10 Dependents: Eligible dependents are the covered employee's spouse and unmarried dependent children until the end of the month that they reach their [21] birthday (includes an unmarried child if incapable of self-support because of physical or mental incapacity that commenced prior to reaching the above age), or the end of the month that they reach their [25] birthday, if attending school full time.
Dependents other than employee's spouse & children:
parents domestic partners (all)
domestic partners (same sex only) domestic partner's children

11 Third party administrator (if applicable): Firm:
Address:
City: County: State: ZIP:
Phone: Fax: E-mail:
Name: Title:

POLICY DETAILS

*The rates listed must support the plan design and benefit selected and must meet all eligibility requirements.
Please refer to your VSP-provided rate sheet for details or contact your VSP Account Executive.
Any discrepancies may preclude acceptance by VSP.*

12 Benefit Year (select one)
Service Year (from last date of service)
Calendar Year (available for clients with January 1 effective dates only)

13 Plan Type (select one):
VSP Signature Plan
Signature Choice
Exam Plus
Exam Plus w/ Allowances
Choice Exam Plus
Choice Exam Plus w/ Allowances

14 Is vision benefit: Core Voluntary Packaged with medical and/or dental
• If Voluntary (vision is included as a stand-alone menu item in a list of benefits to choose from):
Employer contribution percentage: for employee: % for dependent: %
• If Core Plus Options (group provides a basic level of vision coverage to all employees with an option for the employee to buy up or enhance the benefit):
Employer contribution percentage: for employee: % for dependent: %
• If Packaged (vision is tied to which of the following benefits: medical dental).
Employer contribution percentage: for employee: % for dependent: %

Voluntary Participation Structure:
**A minimum number of enrolled employees may apply.*
Exam w/Voluntary Materials* Voluntary Pool 0-24% employer contribution*
Voluntary Pool 25% or more employer contribution* Core Employee/Voluntary Dependent Coverage*

15 Frequency of Service (select one):
A (12/24/24)
B (12/12/24)
C (12/12/12)
Other :
Total co-payment: \$ (applies to exam and eyewear)
OR Split co-payment: \$ 20 exam / \$ 20 eyewear

AGREEMENT

The undersigned client hereby applies for vision care coverage through VSP.

It is understood that:

- A. All future employees will be covered when they become eligible, or offered VSP coverage if voluntary.
- B. Coverage will terminate for an employee on the last day of the month in which employment terminates.
- C. Member past service for clients previously covered by VSP will carry over and remain in force.
- D. This agreement will continue in force [12] months from the effective date. Rates are based on the assumption that VSP will receive these amounts over the full plan term.

This application signed this [] (day) of [] (month) of [] (year).

Firm/Organization: CITY OF HAILEY

Name: RICK DAVIS

Title: MAYOR

Signature: _____

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

BROKER / CONSULTANT

The broker/consultant indicated below is hereby designated Broker of Record by the above signed employer.

Legal Firm Name: CORKERY + JONES BENEFITS INC dba Moloney + O'Neil Benefits

Address: 818 W. RIVERSIDE AVE, SUITE 700

City: SPokane

County: _____

State: WA ZIP: 99201

Phone: (509)343-9203

Fax: _____

E-mail: _____

Contact: MARK NEWBOLD

Title: _____

Broker Assistant Name: PATSY SALES

E-mail: _____

Taxpayer ID: _____

Corporation Independent

Commission Checks Payable to:

Firm Name

Contact Name

Not Paid

Name: _____

Address: _____

City: _____

County: _____

State: _____

ZIP: _____

This application signed this [] (day) of [] (month) of [] (year).

Name: _____

Title: _____

Signature of state-licensed agent: _____

Please send a copy of agent/broker license, if not currently on file with VSP.

16 Client has purchased Enhancements or Specialty Care: yes no

- | | | |
|---|---|---|
| <input type="checkbox"/> Anti-Reflective Coating | <input type="checkbox"/> Elective Contact Lenses, \$150 Allowance | <input type="checkbox"/> Progressive Lenses |
| <input type="checkbox"/> Computer Vision Care | <input type="checkbox"/> Preferred Laser VisionCare (available on a self-funded basis only to clients with 200+ enrolled employees) | <input type="checkbox"/> Safety Eyecare |
| <input type="checkbox"/> Covered Contact Lenses | <input type="checkbox"/> Primary Eyecare | <input type="checkbox"/> Scratch Coating |
| <input type="checkbox"/> Elective Contact Lenses, \$140 Allowance | | <input type="checkbox"/> Second Pair of Glasses |
| | | <input type="checkbox"/> Vision Therapy |

Frame Buy-up (Retail Frame Allowance): \$140 \$150 other \$

Enhancements or Specialty Care benefit service frequency must match the base plan.

17 Requested effective date *(The effective date should not precede the date VSP receives this application.)*

This policy will become effective on the first day of [] (month) [] (year), provided that all of the following has been completed prior to this effective date:

A. VSP has received and accepted this Application.

B. VSP has received and accepted Membership, including the required information of all employees that will be covered under this policy showing name, member ID, and number of dependents, if applicable.

18 This agreement will continue in force [] months from the effective date. Rates are based on the assumption that VSP will receive these amounts over the full plan term.

19 5500 Report Information: Fiscal Year [] through [].
5500 Report will be sent to the person named as the principal contact. A copy of the report may also be sent to your broker and/or your third party administrator.

Please send an additional copy to:

20 Prior VSP coverage: yes no

If yes, prior client name:

21 Names of affiliates or subsidiaries with VSP coverage under a separate contract:

22 *For fully-insured programs (VSP will bill you for your first month's premium)*

	<u># of Employees</u>	<u>x Rates</u>	<u>= Total Remittance</u>
Employee-only or composite rate basis	[]	x \$	= \$
Two, Three- or Four-rate basis	[]	x \$	= \$
	[]	x \$	= \$
	[]	x \$	= \$
	[]	x \$	= \$
			<u>= \$</u>
		Total	= \$

23 *For self-insured programs, Administrative Fee:*

Fixed fee:

or Percent of claims: %

or Dollars per claims: \$