



NOTICE OF SPECIAL COUNCIL MEETING

In accordance with §38-431.01 of the Arizona Revised Statutes of the State of Arizona, notice is hereby given to the Members of City Council and to the general public that the Mayor and Council of the City of San Luis, Arizona, will hold a Special City Council meeting at 6:30 p.m., Tuesday, June 25, 2019. The meeting will take place at the City Council Chambers, located at 1090 E. Union Street, San Luis, Arizona, 85349. Everyone from the public is invited to attend the open meeting.

In accordance with the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973, the City of San Luis does not discriminate on the basis of disability in the admission of or access to, or treatment of employment in its programs, activities, or services. For information regarding rights and provisions of the ADA or Section 504, or to request reasonable accommodations for participation in City programs, activities or services contact: ADA/Section 504 Coordinator, City of San Luis Human Resources Department, 1090 E. Union Street, San Luis, Arizona, 85349; (928) 341-8520.

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

THIS NOTICE IS GIVEN BY:

/s/ Sonia Cornelio, City Clerk

AVISO DE JUNTA ESPECIAL

De acuerdo con los Estatutos del Estado de Arizona A.R.S. §38-431.01, se le informa a los miembros del Cabildo y al público en general que el Alcalde y el Cabildo, tendrán una Junta Especial a las 6:30 p.m., el día Martes 25 de Junio del 2019. La junta se llevará a cabo en la Sala del Cabildo, ubicada en el 1090 E. Union Street, San Luis, Arizona, 85349. El público está cordialmente invitado a la junta.

De acuerdo con el Acta de Americanos con Discapacidades y la Sección 504 del Acta de Rehabilitación del 1973, la Ciudad de San Luis, Arizona no discrimina por causa de discapacidad la admisión y acceso a sus programas, actividades, servicios o en el trato en cuanto a empleo. Para más información referente a derechos y provisiones del Acta de Americanos con Discapacidades o Sección 504, o para solicitar adaptaciones que sean razonables para la participación en programas, actividades o servicios de la Ciudad, contactar al: Coordinador del Acta de Americanos con Discapacidades/Sección 504, Departamento de Recursos Humanos de la Ciudad de San Luis, Arizona, ubicado en el 1090 E. Union Street, San Luis, Arizona, 85349; (928) 341-8520.

Por medio de este aviso y de acuerdo con los Estatutos del Estado de Arizona A.R.S §1-602.A.9, sujeto a ciertas excepciones reglamentarias, los padres de familia tienen el derecho de dar el consentimiento ante el Estado o cualquiera de sus subdivisiones políticas para hacer una grabación de audio o video de su hijo menor de edad. Las juntas del Cabildo se graban en audio y/o video y como resultado, el hecho de que haya menores presentes puede ser sujeto a que sean grabados. Para que los padres de familia puedan ejercer sus derechos pueden dar el consentimiento por escrito con la Secretaria de la Ciudad a tal grabación, o tomar acción personal para asegurarse que su hijo menor no esté presente cuando la grabación se lleve a cabo. Si un menor de edad está presente en el momento de la grabación, la Ciudad asumirá que los padres de familia están cediendo los derechos sobre una posible grabación de acuerdo con los Estatutos del Estado de Arizona A.R.S. §1-602.A.9.

ESTE AVISO ES DADO POR:

/f/ Sonia Cornelio, Actuaría de la Ciudad



AMENDED AGENDA

6/24/2019

**AGENDA
Special Meeting
San Luis City Council
San Luis Council Chambers
1090 E. Union Street
San Luis, AZ 85349
June 25, 2019
6:30 p.m.**

MEMBERS OF THE CITY COUNCIL WILL ATTEND EITHER IN PERSON, TELEPHONE, OR VIDEO CONFERENCE COMMUNICATION

1. CALL TO ORDER/ROLL CALL

2. PLEDGE OF ALLEGIANCE

3. INVOCATION

4. CONSENT AGENDA

All matters are considered to be routine by the City Council and will be enacted by one motion. If discussion is desired, that item will be removed from the Consent Agenda and will be considered separately.

4. A. MINUTES OF

- Regular Council meeting held May 22, 2019
- Work Session held June 5, 2019

4. B. DISBURSEMENTS FROM June 1, 2019 THROUGH June 14, 2019.

Total Disbursements \$1,287,924.31

(One Million, Two Hundred Eighty-Seven Thousand, Nine Hundred Twenty-Four Dollars and Thirty-One Cents)

4. C. Discussion and possible action on any and all matters regarding the purchase of 17 Mobile Data Computers (MDCs) with associated hardware to be purchased using funding approved by an Intergovernmental Agreement under Subrecipient Agreement Number 180436-02, Operation Stonegarden Grant Program Award. **(Richard Jessup, Chief of Police)**

4. D. Discussion and possible action on any and all matters regarding Memorandum of Understanding between the City of San Luis and Comite de Bienestar Inc. for the proposed Lot Split Case No. 2019-0113. **(Jose A. Guzman, Director of Planning and Zoning)**

5. DISCUSSION AND POSSIBLE ACTION ITEMS:

5. A. Discussion and possible action on any and all matters regarding the City of San Luis offering to provide congregate meals nutrition services at the Senior Center in exchange for WACOG providing up to \$74,400.00 to support the service. **(Lizandro Galaviz, Director of Parks & Recreation)**

5. B. Discussion and possible action on any and all matters regarding proposals from Border Gym Fitness, L.L.C. and 24/7 Get Fit Gym. **(Fausto Gonzalez, HR Training & Programs Coordinator)**
5. C. Discussion and possible action on any and all matters regarding Order No. 2019-5. An order of the Mayor and City Council of the City of San Luis, Arizona implementing a uniform video and cable service license, a standard form application with an affidavit by mandate of the Arizona Legislature. (ITEM CONTINUED FROM REGULAR COUNCIL MEETING HELD MAY 22, 2019) **(Kay Marion Macuil, City Attorney)**
5. D. Discussion and possible action on any and all matters regarding employee benefits contracts which are not administered by the San Luis Employee Benefits Trust. **(Maria Muñoz, Human Resources Technician)**
5. E. Discussion and possible action on any and all matters regarding Order No. 2019-7. An order of the Mayor and City Council of the City of San Luis, Arizona declaring the Employee Benefits Plans a public record; approving the Employee Benefits Plans for the fiscal year 2019-2020 for administration by the San Luis Employee Benefits Trust; providing for repeal of conflicting actions of City Council; providing for severability; and establishing an effective date for the plans. **(Edgardo Carbajal, HR Recruitment Coordinator and Maria Muñoz, HR Benefits Coordinator)**
5. F. Discussion and possible action on any and all matters regarding the annual pension funding policy for public safety personnel required by HB 2097. **(Monica Castro, Finance Director)**
5. G. Public hearing followed by discussion and possible action on any and all matters regarding Resolution No. 2083. A resolution of the City of San Luis, Arizona, adopting the budget for Fiscal Year 2019 - 2020. **(Monica Castro, Director of Finance)**
- A. Open public hearing
1. Staff Presentation
2. Call to the Public on this Item
- B. Close public hearing
- C. Action on Resolution No. 2083

6. **SUMMARY OF CURRENT EVENTS**

Events by Mayor, Council Members and/or City Manager pursuant to A.R.S. §38-431.02 (K).

7. **CALL TO THE PUBLIC**

This is the time for the public to comment. Members of the City Council may not discuss items that are not specifically identified on the agenda. Therefore, pursuant to A.R.S. §38-431.01 (H), action taken as a result of public comment will be limited to directing staff to study the matter, responding to any criticism or scheduling the matter for further consideration and decision at a later date.

8. **EXECUTIVE SESSION**

Vote to hold an Executive Session pursuant to A.R.S. §§38-431.03(A)(3) and 38-431.03(A)(4)

Discussion and possible action to hold an Executive Session pursuant to A.R.S. §38-431.03(A)(3) and A.R.S. §38-431.03(A)(4) on any and all matters regarding consultation with the city's attorneys for legal advice and or in order for City Council to consider its position

and instruct its attorneys regarding its position regarding contracts that are the subject of negotiations, in pending or contemplated litigation or in settlement discussions conducted in order to avoid or resolve litigation concerning the manganese filtration system at Well Site No. 7. **(Kay Marion Macuil, City Attorney)**

9. MOTION TO GO BACK INTO SPECIAL SESSION

10. DISCUSSION AND POSSIBLE ACTION ITEM:

Discussion and possible action on any and all matters regarding the approval and ratification to engage outside counsel to litigate Yuma County Superior Court Civil Case No. S1400 CV 2019 00321. **(City Council and Kay Marion Macuil, City Attorney)**

11. ADJOURNMENT



AGENDA ITEM REVIEW FORM

Special City Council Meeting

4.A.

Meeting Date: 06/25/2019

Summary

MINUTES OF

- Regular Council meeting held May 22, 2019
 - Work Session held June 5, 2019
-

Attachments

5/22/2019 RCM

6/5/2019 WS

MINUTES
Regular Council Meeting
San Luis City Council
San Luis Council Chambers
1090 E. Union Street
May 22, 2019
7:00 p.m.

1. CALL TO ORDER/ROLL CALL: Mayor Gerardo Sanchez called the Regular City Council meeting to order at approximately 7:00 p.m.

PRESENT: Mayor Gerardo Sanchez
Vice Mayor Maria Cecilia Ramos
Council Member Mario Buchanan Jr.
Council Member Africa Luna-Carrasco
Council Member Gloria Torres

ABSENT: Council Member Jose Ponce
Council Member Matias Rosales

OTHERS PRESENT: Tadeo A. De La Hoya, City Manager
Sonia Cornelio, City Clerk
Kay Marion Macuil, City Attorney
Angel Ramirez, Fire Chief
Axel Chayra, IT Technician
Eulogio Vera, Director of Public Works
Francia Alonso, Public Information Officer/Assistant to Council
Isaac Gutierrez, GIS Specialist
Jesus Meza, Assistant Director of Parks & Recreation
Jorge Perez, Billing & Collections Manager
Jose A. Guzman, Director of Planning & Zoning
Marco Santana, Police Lieutenant
Alex Joe Harper, Resident
Carmen Merida, Resident
Cesar Neyoy, Reporter
Christian Cuevas, Simultaneous Interpreter
Concepcion Ulloa, Resident
David Lara, Resident
Juanita Toledo, Resident
Lucy Lopez, Reporter
Jesse Lugo, Visitor
John Starkey, Visitor
Maria Gonzalez, Visitor
Mark Concha, Resident
Maria Nuñez, Resident
Maria Robles, Resident
Najeh Edais, Edais Engineering

2. PLEDGE OF ALLEGIANCE

The Pledge of Allegiance was led by Council Member Mario Buchanan Jr.

3. INVOCATION

The invocation was led by Mr. Richard Jessup, Chief of Police.

4. PROCLAMATION

4. A. Proclamation – National Public Works Week May 19-25, 2019

Ms. Sonia Cornelio, City Clerk, read the proclamation in its entirety.

Mayor Gerardo Sanchez proclaimed May 19-25, 2019 as National Public Works Week in the City of San Luis. He thanked the Public Works employees for the dedication and making a difference in the community.

5. CONSENT AGENDA

5. A. MINUTES OF

- Work Session held April 17, 2019
- Regular Council meeting held April 24, 2019

5. B. DISBURSEMENTS FROM APRIL 27, 2019 THROUGH MAY 10, 2019

Total Disbursements \$587,710.99

(Five Hundred Eighty-Seven Thousand, Seven Hundred Ten Dollars and Ninety-Nine Cents)

MOTION: Council Member Africa Luna-Carrasco/Council Member Mario Buchanan Jr. to approve the consent agenda as presented. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Ramos	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Gloria Torres	Aye

6. DISCUSSION AND POSSIBLE ACTION ITEMS:

6. A. Discussion and possible action on any and all matters regarding Resolution No. 2074. A resolution of the Mayor and City Council of the City of San Luis, Arizona directing the City Manager to establish and implement a plan for the fiscal year 2019-2020 for reduction in force and in civic contributions to ensure that city expenses do not exceed city revenues; superseding any conflicting provisions of the city; and

providing for severability; and declaring an emergency. (Tadeo A. De La Hoya, City Manager)

Mr. Tadeo A. De La Hoya, City Manager, informed that this resolution is presented as in previous years as a precautionary measure in case of a shortfall in revenues.

Mayor Gerardo Sanchez explained that this resolution is not intended to do any layoffs as this is the last option. He informed that this resolution is just a formality, he suggested tabling this resolution, as there is no emergency.

Ms. Kay Marion Macuil, City Attorney, asked Mayor Sanchez if the item will be continued to a different meeting or if it will be tabled definitely.

Mayor Gerardo Sanchez replied that this resolution would be tabled definitely, but if an emergency arises and one is needed, staff can draft a new resolution. Currently, staff is still working in the budget, at no point the city is ready to reduce its labor force or thinking of laying off anyone.

MOTION: Mayor Gerardo Sanchez/Council Member Africa Luna Carrasco to table Resolution No. 2074. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Ramos	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Gloria Torres	Aye

6. B. Discussion and possible action on any and all matters regarding the ratification of the purchase for a new Emergency Incident Command Vehicle. (Angel Ramirez, Fire Chief)

Mr. Angel Ramirez, Fire Chief, informed that this item was presented before council on January 23, 2019, and it was approved. He stated that there was a misunderstanding on the quote provided by Emergency Vehicle Group, which was not able to use the discount code on the pricing of the vehicle. He informed that in order to receive the discounted price, the city had to split the purchase between two (2) vendors. The purchase of the truck will be directly from Selman Chevrolet Co., and the uplifting will be done by Emergency Vehicle Group. The price will remain the same as previously approved. Mr. Ramirez asked for approval of the ratification of the purchase orders.

MOTION: to ratify purchase orders 201-00002580 under Emergency Vehicle Group in the amount of \$31,932.00 plus tax and 2019-00002601 under Selman Chevrolet Co., in the amount of \$37,575.68 plus tax, both purchase order not to exceed the amount of \$74,000.00 Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Ramos	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Gloria Torres	Aye

6. C. Public hearing followed by discussion and possible action on any and all matters regarding the recommendation of a Special Event Liquor License application to the Arizona Department of Liquor Licenses and Control to authorize the City of San Luis Parks & Recreation Department to sell alcohol at the 4th of July Celebration to be held July 4, 2019. (Lizandro Galaviz, Director of Parks and Recreation)

A. Open public hearing

MOTION: Council Member Africa Luna Carrasco/Council Member Mario Buchanan Jr. to open the public hearing. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Ramos	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Gloria Torres	Aye

1. Presentation by staff and/or applicant

Mr. Jesus Meza, Assistant Director of Parks & Recreation, informed that the City of San Luis Parks & Recreation would be working with the San Luis FRONTERA Rotary Club in the sale of alcohol during the 4th of July celebration. He informed that the San Luis FRONTERA Rotary club would be in charge of selling the alcohol to the public and they will be obtaining the Liability Insurance for this event.

2. Call to the public on this item

There was no questions and/or comments from council and the public.

B. Close public hearing

MOTION: Council Member Mario Buchanan Jr./Council Member Africa Luna-Carrasco to close the public hearing. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Ramos	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Gloria Torres	Aye

C. Action on Special Event Liquor License Application to the Arizona Department of Liquor Licenses & Control

MOTION: Council Member Mario Buchanan Jr./Council Member Africa Luna Carrasco to recommend approval to the Arizona Department of Liquor Licenses and Control the Special Event Liquor License Application for the City of San Luis, Parks & Recreation Department as presented. Motion passed with 4 ayes and 1 nay from Vice-Mayor Maria Cecilia Ramos.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Ramos	Nay
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Gloria Torres	Aye

6. D. Discussion and possible action on any and all matters regarding Order No. 2019-5. An order of the Mayor and City Council of the City of San Luis, Arizona implementing a uniform video and cable service license, a standard form application with an affidavit by mandate of the Arizona Legislature. (Kay Marion Macuil, City Attorney)

Ms. Kay Marion Macuil, City Attorney, asked Mayor and Council to continue this item to a meeting in June. She informed that this should be done by July, there are other cities in Arizona that are doing other changes and she would like to do more research.

MOTION: Vice-Mayor Maria Cecilia Ramos/Council Member Mario Buchanan Jr. to continue this item to a meeting in June. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Ramos	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Gloria Torres	Aye

6. E. Public hearing followed by discussion and possible action on any and all matters regarding Rezoning Case No. 2019-0224 and Ordinance No. 390. An ordinance of the Mayor and City Council of the City of San Luis, Arizona, amending the official zoning map of the City of San Luis by changing the zoning classification of 30.3 acres from Medium-High Density Residential (R-2) to Medium Density Residential (R1-6) for property located on the northeast corner of County 24th Street and 20th Avenue. (Jose A. Guzman, Director of Planning and Zoning)

A. Open public hearing

MOTION: Council Member Africa Luna-Carrasco/Council Member Mario Buchanan Jr. to open the public hearing. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Ramos	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Gloria Torres	Aye

1. Staff presentation

Mr. Jose A. Guzman, Director of Planning & Zoning, informed that this request was submitted by Edais Engineering, Inc. on behalf of the owner Riedel Holdings, LLC. This request is to rezone 30.3 acres from Medium-High Density Residential (R-2) to Medium Density Residential (R1-6) and High-Density Residential (R-3). He informed that the reason for this request to do a residential subdivision that will consist of 123 lots and is inconsistent with the General Plan designation. He stated that staff is recommending approval of the request.

Mayor Gerardo Sanchez asked if the Planning & Zoning Commission reviewed the request and if there were any questions from the commission.

Mr. Guzman informed that there was a condition pending on an older ordinance, and after review, it was determined that those conditions were not applicable because the agreement expired in 2012.

2. Call to the Public on this item

There was no comments and/or commented from council and the public.

B. Close public hearing

MOTION: Council Member Mario Buchanan Jr./Council Member Africa Luna Carrasco to close the public hearing. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Ramos	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Gloria Torres	Aye

C. Approval of Reading of Ordinance No. 390 by title only

MOTION: Council Member Africa Luna Carrasco/Vice-Mayor Maria Cecilia Ramos to approve reading of Ordinance No. 390 by title only. Motion passed unanimously.

Ms. Sonia Cornelio, City Clerk, read Ordinance No. 390 by title only.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Ramos	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Gloria Torres	Aye

D. Action on Ordinance No. 390

MOTION: Council Member Africa Luna Carrasco/Council Member Mario Buchanan Jr. to approve Ordinance No. 390. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Ramos	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Gloria Torres	Aye

7. SUMMARY OF CURRENT EVENTS

Vice-Mayor Maria Cecilia Ramos informed that Mr. Kiko Munro, Presidente Municipal for Puerto Peñasco, Sonora, Mexico made an announcement that great things will be coming to Puerto Peñasco and requested the region for support.

Mayor Gerardo Sanchez thanked Comite de Bienestar, St. Jude Thaddeus Parish, and other organizations for the support given and stepping out by helping the asylum seekers in the community.

8. CALL TO THE PUBLIC

Mr. David Lara, 1032 6th Drive, San Luis, AZ, commented that by reading the newspaper and item 6. A. it seems to contradict because there was an emergency and now there is no emergency. He mentioned that if money is needed, City Council should start by taking a cut of their salary. He commented that there are employees that are politically protected and should not be employed anymore. He mentioned that there are lot of ways to find money without sacrificing good quality employees. He asked Mayor Sanchez to be careful on how money is spent, do not protect certain employees, do what is right, and tighten the belt as everybody does. He asked council to get the facts straight.

Ms. Diane Umphress, Amberly's Place, 1310 S. 3rd Avenue, Yuma, AZ, informed that the reason for being present during this meeting is because during the last work session a concern was created, regarding the service provided by her agency. She stated that a conversation with her staff was taken regarding the services her agency provides to San Luis Municipal Court. She added that Kay Marion Macuil, City Attorney, provided her with copies of the State Statute regarding the courts. In Yuma County, in the court if there are children involved or if it is a marriage situation with domestic violence, it is a customary practice that those victims are taken to JP Court or the Superior Court because if there is going to be custody issues, they need to follow on that. Furthermore, she informed that the following day, the advocate went to the Municipal Court and the City Prosecutor's office to make the relationship stronger so that better services can be provided to the victims. Ms. Umphress stated that if in the future, there are any issues or concerns, to please inform her to address those issues. She provided copies of the AZPOST training provided to the San Luis Police Department on Predominant Aggressive for Domestic Violence on strangulation and human trafficking. Also, a letter from Judge David Haws regarding what is customary for orders of protection to provide a background. She asked Mayor and Council if they have any questions or concerns to please contact her. She stated that the City of San Luis support is needed to able to support the victims that live in San Luis.

Ms. Maria Nuñez, 1449 Arden Avenue, San Luis, AZ, supported Ms. Umphress on her request and asked Mayor and Council to continue supporting this agency. She asked Mayor and Council to please reconsider their salaries and take a cut to lower the deficit. She asked to please use ethical values. Ms. Nuñez thanked Mr. Tadeo A. De La Hoya as part of the Gadsden School District for using their funds to pave their street for parents and children. She asked to please do not forget Arden Avenue.

Ms. Guillermina Fuentes, 1630 N. 9th Avenue, San Luis, AZ, addressed Mr. Lara's comment to council "be aware on where you spend your money, so you can save it," "you are not trying to save the money for our community." She asked Mayor and Council to do what Mr. Lara is requesting, so that wealthy people can abuse the public money of welfare, like ACCHS and family assistance benefits. She mentioned that she had seen a lot of negative comments on the proposed property tax. She added that this tax was to make San Luis a better community. She stated that the reason the proposed tax was not approved by the voters was the lack of promotion of this tax. Furthermore, she stated that all those people that criticize the local government should help in the betterment of the community.

9. ADJOURNMENT

MOTION: Council Member Mario Buchanan Jr./Vice-Mayor Maria Cecilia Ramos to adjourn the meeting at approximately 7:40 p.m. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Ramos	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Gloria Torres	Aye

MINUTES
Work Session
San Luis City Council
San Luis Council Chambers
1090 E. Union Street
June 5, 2019
6:45 p.m.

1. CALL TO ORDER/ROLL CALL: Mayor Gerardo Sanchez called the Work Session to order at approximately 6:33 p.m.

PRESENT: Mayor Gerardo Sanchez
Vice Mayor Maria Cecilia Ramos
Council Member Mario Buchanan Jr.
Council Member Africa Luna-Carrasco
Council Member Matias Rosales

ABSENT: Council Member Gloria Torres
Council Member Jose Ponce

OTHERS PRESENT: Tadeo A. De La Hoya, City Manager
Jose L. Cisneros, Acting City Clerk
Glenn Gimbut, Assistant City Attorney
Angel Ramirez, Fire Chief
Aracely De La Hoya, Senior Services Manager
Carlos Cortes, Assistant Director of Finance
Francia Alonso, PIO/Assistant to Council
Jorge Mungaray, IT Technician
Jorge Perez, Billing & Collections Manager
Jose A. Guzman, Director of Planning & Zoning
Lizandro Galaviz, Director of Parks & Recreation
Monica Casto, Director of Finance
Richard Jessup, Chief of Police
Ric Bauermann, Fire Inspector
Maria Robles, Resident
Maria Nuñez, Resident

2. ITEMS FOR DISCUSSION ONLY

2. A. Presentation followed by discussion on any and all matters regarding the San Luis 2040 General Plan Update process. (Martin Scribner, Matrix Design Group, Inc.)

Mr. Martin Scribner, Matrix Design Group, Inc., made a power point presentation to Mayor and Council. This presentation included the following, What is a General Plan?, Project Information and Project Status. A copy of this presentation is on file with the complete agenda packet filed in the City Clerk's Office.

2. B. Discussion and possible directions to staff on any and all matters regarding an Intergovernmental Agreement between the City of San Luis and the City of Phoenix to access Transaction Privilege Tax data supplied by the Arizona Department of Revenue. (Monica Castro, Director of Finance)

Ms. Monica Castro, Director of Finance, informed that this agreement would allow San Luis to use their system to access San Luis's data supplied by the Arizona Department of Revenue. She stated that by having access to this system, it would add value to the city of San Luis. She added that there is a one time set up fee of \$2,000.00. From there on, there is an annual fee of \$375.00 to be payed while the agreement is in place. She mentioned that for next year's budget, three (3) departments will benefit from this system and will share the costs. Those departments are: Finance, Utilities and Economic Development. Ms. Castro asked Mayor and Council to consider this request as this will benefit the city.

2. C. Discussion and possible directions to staff on any and all matters regarding the approval of Lighting and Retention Basin Assessment Districts Budget for Fiscal Year 2019-2020. (Carlos Cortes, Assistant Director of Finance)

Mr. Carlos Cortes, Assistant Director of Finance, informed that these districts were formed to provide lighting and retention basin maintenance in the developments. He stated that the County of Yuma requires Council's approval in order to levy the assessments. He added that the amounts are based on the estimated cost the city will incur to provide these services. Mr. Cortes informed that staff have reviewed the cost estimates and found that revenues will be increased by \$40,100.00; this will give a total assessment of \$432,260.00.

2. D. Discussion and possible directions to staff on any and all matters regarding the purchase of 17 Mobile Data Computers (MDCs) with associated hardware to be purchased using funding approved by an Intergovernmental Agreement under Subrecipient Agreement Number 180436-02, Operation Stonegarden Grant Program Award. (Richard Jessup, Chief of Police)

Mr. Richard Jessup, Chief of Police, informed that the San Luis Police Department had been awarded \$60,000.00 from Operation Stonegarden Grant Program, to purchase 12 Mobile Data Computers. He stated that staff was able to purchase 17 instead of the 12 because the prices of the computer went down and the grant program approved the purchase of the 17 computers. He informed that these computers would be specifically used to support Operation Stonegarden.

2. E. Discussion and possible directions to staff on any and all matters regarding a contract with Lantis Productions, Inc., for a fireworks presentation during the 4th of July Celebration. (Lizandro Galaviz, Director of Parks & Recreation)

Mr. Lizandro Galaviz, Director of Parks & Recreation, informed that this contract would authorize staff to contract with Lantis Productions, Inc., for the fireworks presentation during the 4th of July Celebration. He added that the contract is still in review by the city attorney, the contract is the same as in previous years.

2. F. Discussion and possible directions to staff on any and all matters regarding the waiving of formal purchase procedures under City Code-Purchasing Section 36.01(H) for the rental of inflatable slides from Poly's Party Rentals for the 4th of July Celebration. (Lizandro Galaviz, Director of Parks and Recreation)

Mr. Lizandro Galaviz, Director of Parks & Recreation, informed that staff had looked with local vendors for the rentals of inflatable slides, but they do not have the same inventory as Poly's Party Rentals. He stated that for this reason staff has requested the waiving of purchasing procedures as allowed by the San Luis City Code.

2. G. Discussion and possible directions to staff on any and all matters regarding updates on the San Luis Senior Center and the collaboration with the Western Arizona Council of Governments (WACOG). (Lizandro Galaviz, Parks and Recreation Director and Aracely De La Hoya, Senior Services Manager)

Mr. Lizandro Galaviz, Director of Parks & Recreation, informed that the City of Somerton was overseeing the Senior Center nutrition program; this year they opted not to continue to provide that service. He stated that Western Arizona Council of Government (WACOG) was informed and approached the city about taking over of the program. He added that staff is working with the legal and finance departments on contract details. Mr. Galaviz informed that WACOG has been very supportive and willing to work with the city to provide assistance. He added that WACOG had offered the use of a van for the Senior Center for the use of transportation for senior activities. This vehicle is 2014 with 2,000 miles on it.

Vice Mayor Maria Cecilia Ramos asked if there was a disagreement between the City of Somerton and the City of San Luis on this program and asked if additional employees will be needed to run the program through WACOG.

Mr. Galaviz replied that there was no misunderstanding; this change is due to funding sources and stated that a cook would be needed; this position will need certain certifications.

2. H. Discussion and possible directions to staff on any and all matters regarding Resolution No. 2076. A resolution of the Mayor and City Council of the City of San Luis, Arizona, creating a Street Lighting Improvement District and declaring its intention to purchase electricity, and maintain poles, luminaries, and underground conduit, together with a charge for the use of lighting facilities, for lighting public streets within an area described as Bienestar Estates 10 Subdivision, San Luis, Arizona. (Jose A. Guzman, Director of Planning & Zoning).

Mr. Jose A. Guzman, Director of Planning & Zoning, informed that item 2.H. through 2.N. are for Bienestar Estates 10 Subdivision improvement districts. He informed that this subdivision is located in the corner of Avenue F and County 24th Street and consists of 40 acres that will be divided into 163 lots. This subdivision is still under review and will be presented to Mayor and Council in a meeting in June. He stated that improvement districts are required by the subdivision regulations. He added that this resolution is to create a Street Lighting Improvement District.

2. I. Discussion and possible directions to staff on any and all matters regarding Resolution No. 2077. A resolution of the Mayor and City Council of the City of San Luis, Arizona, declaring its intention to provide the Enhanced Municipal Services Improvement District of operating and maintaining certain retention basins within the area described as Bienestar Estates 10 Subdivision, San Luis, Arizona. (Jose A. Guzman, Director of Planning & Zoning)

Mr. Jose A. Guzman, Director of Planning & Zoning, informed that this resolution is for the Enhanced Municipal Services District to operate and maintain retention basins on Bienestar Estates 10 Subdivision.

2. J. Discussion and possible directions to staff on any and all matters regarding Resolution No. 2078. A resolution of the Mayor and City Council of the City of San Luis, Arizona declaring its intention to provide the Enhanced Municipal Services of maintaining and repairing certain landscape improvements included within, near and adjacent to the retention and detention basins and parking and parkways and related facilities together with appurtenant structures within the area described as Bienestar Estates 10 Subdivision, San Luis, Arizona. (Jose A. Guzman, Director of Planning & Zoning)

Mr. Jose A. Guzman, Director of Planning & Zoning, informed that this resolution is for the Enhanced Municipal Services District to maintain and repair landscape area included within, near and adjacent to the retention and detention basins and parking and parkways and related facilities with appurtenant structures on Bienestar Estates 10 Subdivision.

2. K. Discussion and possible directions to staff on any and all matters regarding Resolution No. 2079. A resolution of the Mayor and City Council of the City of San Luis, Arizona, authorizing and directing the city engineer to order the purchase of electricity and to order the maintenance of poles, luminaries and underground conduit incident to the installation of street lights for lighting public streets within the area described as Bienestar Estates 10 Subdivision, San Luis, Arizona. (Jose A. Guzman, Director of Planning & Zoning)

Mr. Jose A. Guzman, Director of Planning & Zoning, informed that this resolution is to authorize and direct the city engineer to order the purchase of electricity and to order the maintenance of poles, luminaries and underground conduit incident to the installation of street lights for lighting public streets within the area described as Bienestar Estates 10 Subdivision.

Mr. Glenn Gimbut, Assistant City Attorney, asked what is the difference of Resolution No. 2076 and No. 2079, as both are for street lighting on Bienestar 10.

Mr. Guzman replied that Resolution No. 2076 is to create the improvement district, and Resolution No. 2079 is for the order of services.

2. L. Discussion and possible directions to staff on any and all matters regarding Resolution No. 2080. A resolution of the Mayor and City Council of the City of San Luis Arizona, authorizing and directing the city engineer to order the operation and maintenance of certain retention basins for the area described as Bienestar 10 Subdivision, San Luis, Arizona. (Jose A. Guzman, Director of Planning & Zoning)

Mr. Jose A. Guzman, Director of Planning & Zoning, informed that this resolution is for the order of services for the retention basins on Bienestar Estates 10 Subdivision.

2. M. Discussion and possible directions to staff on any and all matters regarding Resolution No. 2081. A resolution of the Mayor and City Council of the City of San Luis, Arizona, authorizing and ordering the operation, maintenance and repair of certain landscape improvements included within, near and adjacent to the retention and detention basins and parking and parkways and related facilities together with appurtenant structures for the area described as Bienestar Estates 10 Subdivision, San Luis, Arizona. (Jose A. Guzman, Director of Planning & Zoning)

Mr. Jose A. Guzman, Director of Planning & Zoning, informed that this resolution is for the order of services for landscaping on Bienestar Estates 10 Subdivision.

2. N. Discussion and possible directions to staff on any and all matters regarding Resolution No. 2082. A resolution of the Mayor and City Council of the City of San Luis, Arizona ordering and declaring the formation of Bienestar Estates 10 Community Facilities District (City of San Luis, Arizona). (Jose A. Guzman, Director of Planning & Zoning)

Mr. Jose A. Guzman, Director of Planning & Zoning, informed that this resolution order and declare the formation of Bienestar Estates 10 Subdivision Community Facilities District.

Mayor Gerardo Sanchez thanked everyone involved in this project.

3. ADJOURNMENT

MOTION: Council Member Africa Luna-Carrasco/Council Member Mario Buchanan Jr. to adjourn the meeting at approximately 7:26 p.m. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Ramos	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Matias Rosales	Aye



AGENDA ITEM REVIEW FORM

Special City Council Meeting

4.B.

Meeting Date: 06/25/2019

Summary

DISBURSEMENTS FROM June 1, 2019 THROUGH June 14, 2019.

Total Disbursements \$1,287,924.31

(One Million, Two Hundred Eighty-Seven Thousand, Nine Hundred Twenty-Four Dollars and Thirty-One Cents)

Attachments

Disbursements 6-25-2019



City of San Luis

Finance Department

COUNCIL MEETING JUNE 25, 2019 Disbursement Reports from 6/1/2019 to 6/14/2019

<u>Bank Accounts</u>	<u>Check Date</u>	<u>Amount</u>	<u>Schedule</u>
Accounts Payable Check Account	6/6/2019	\$ 290,160.56	Schedule A
Payroll Check Account	6/10/2019	\$ 4,505.65	Schedule B
Payroll Check Account	6/12/2019	\$ 313,859.81	Schedule C
Accounts Payable Check Account	6/13/2019	\$ 679,398.29	Schedule D

Total Disbursements: \$ 1,287,924.31

Please contact Ms. Monica Castro prior to the meeting if additional information is needed.

Prepared by Angelica V. Castro:

Verified by Director of Finance:

For Council approval on: _____

Mayor: _____

Council: _____

RECEIVED

2019 JUN 17 P 12:32

CITY OF SAN LUIS
OFFICE OF THE CITY CLERK

Payment Register

From Payment Date: 6/3/2019 - To Payment Date: 6/6/2019

Number	Date	Status	Void Reason	Reconciled/ Voided Date	Source	Payee Name	Transaction Amount	Reconciled Amount	Difference
89702	06/06/2019	Open			Accounts Payable	LOPEZ, ENRIQUE	\$226.80		
89703	06/06/2019	Open			Accounts Payable	PETTY CASH/ ANGELICA CIFUENTES	\$489.03		
89704	06/06/2019	Open			Accounts Payable	RAMIREZ MUNGUIA, ARTURO, I	\$154.00		
89705	06/06/2019	Open			Accounts Payable	REAL PURIFIED WATER LLC	\$35.00		
89706	06/06/2019	Open			Accounts Payable	SAN LUIS AIR CONDITIONING LLC	\$200.00		
89707	06/06/2019	Open			Accounts Payable	SUPREME PLUMBING SOLUTIONS LLC	\$600.00		
89708	06/06/2019	Open			Accounts Payable	YUMA BOYS BASEBALL LEAGUE	\$300.00		
Type Check Totals:							\$290,160.56		
1BYPAYABLE - 1st BY Accounts Payable Totals									

Checks	Status	Count	Transaction Amount	Reconciled Amount
	Open	101	\$290,160.56	\$0.00
	Reconciled	0	\$0.00	\$0.00
	Voided	0	\$0.00	\$0.00
	Stopped	0	\$0.00	\$0.00
	Total	101	\$290,160.56	\$0.00

All	Status	Count	Transaction Amount	Reconciled Amount
	Open	101	\$290,160.56	\$0.00
	Reconciled	0	\$0.00	\$0.00
	Voided	0	\$0.00	\$0.00
	Stopped	0	\$0.00	\$0.00
	Total	101	\$290,160.56	\$0.00

Grand Totals:

Checks	Status	Count	Transaction Amount	Reconciled Amount
	Open	101	\$290,160.56	\$0.00
	Reconciled	0	\$0.00	\$0.00
	Voided	0	\$0.00	\$0.00
	Stopped	0	\$0.00	\$0.00
	Total	101	\$290,160.56	\$0.00

All	Status	Count	Transaction Amount	Reconciled Amount
	Open	101	\$290,160.56	\$0.00
	Reconciled	0	\$0.00	\$0.00
	Voided	0	\$0.00	\$0.00
	Stopped	0	\$0.00	\$0.00
	Total	101	\$290,160.56	\$0.00

Angelica V. Castro
6/6/2019
C

Payment Register

From Payment Date: 6/3/2019 - To Payment Date: 6/6/2019

Number	Date	Status	Void Reason	Reconciled/ Voided Date	Source	Payee Name	Transaction Amount	Reconciled Amount	Difference
89655	06/06/2019	Open			Accounts Payable	TORRES, ALEJANDRA, S	\$847.44		
89656	06/06/2019	Open			Accounts Payable	VALENCIA, RODRIGO	\$336.00		
89657	06/06/2019	Open			Accounts Payable	ANGEL'S TOWING SERVICE/AUTO SALES	\$75.00		
89658	06/06/2019	Open			Accounts Payable	BINGHAM AUTO & TRUCK PARTS	\$469.64		
89659	06/06/2019	Open			Accounts Payable	BORDER CONSTRUCTION SPECIALTIES	\$3,189.84		
89660	06/06/2019	Open			Accounts Payable	CENTURYLINK	\$6,651.06		
89661	06/06/2019	Open			Accounts Payable	COUNTY RV REPAIR & SALES LLC	\$1,080.16		
89662	06/06/2019	Open			Accounts Payable	FAUSTO LOPEZ, MARVYN	\$191.00		
89663	06/06/2019	Open			Accounts Payable	GOMEZ, SONIA	\$15.00		
89664	06/06/2019	Open			Accounts Payable	GUERRA, BRENDA	\$130.00		
89665	06/06/2019	Open			Accounts Payable	GUTIERREZ ZEPEDA, FRANCISO	\$224.00		
89666	06/06/2019	Open			Accounts Payable	IBARRA HIGUERA, PEDRO	\$50.00		
89667	06/06/2019	Open			Accounts Payable	KINGHOSE INDUSTRY LLC	\$92.03		
89668	06/06/2019	Open			Accounts Payable	LEON SEPULVEDA, ROSARIO	\$167.00		
89669	06/06/2019	Open			Accounts Payable	MEJIA, ERIC	\$375.00		
89670	06/06/2019	Open			Accounts Payable	MEJIA, JOSE, M	\$171.83		
89671	06/06/2019	Open			Accounts Payable	MGM INTERNET SOLUTIONS, INC	\$108.00		
89672	06/06/2019	Open			Accounts Payable	NAVARRO, CAROLINE	\$200.00		
89673	06/06/2019	Open			Accounts Payable	PALACIOS, RAYMUNDO	\$500.00		
89674	06/06/2019	Open			Accounts Payable	PURCELL TIRE CO.	\$471.52		
89675	06/06/2019	Open			Accounts Payable	QUINONEZ, FRANCISCO	\$200.00		
89676	06/06/2019	Open			Accounts Payable	REDBURN TIRE COMPANY	\$1,993.40		
89677	06/06/2019	Open			Accounts Payable	SAMANA HOME BUILDERS, LLC	\$6,624.00		
89678	06/06/2019	Open			Accounts Payable	SAN LUIS AIR CONDITIONING LLC	\$450.00		
89679	06/06/2019	Open			Accounts Payable	SAN LUIS WALK IN CLINIC, INC	\$1,250.00		
89680	06/06/2019	Open			Accounts Payable	THE ROACH PEST CONTROL	\$140.00		
89681	06/06/2019	Open			Accounts Payable	THOMSON WEST PUBLISHING CO.	\$998.59		
89682	06/06/2019	Open			Accounts Payable	VILLEGAS, ALICIA	\$94.00		
89683	06/06/2019	Open			Accounts Payable	YUMA AUTO REBUILDERS	\$2,348.83		
89684	06/06/2019	Open			Accounts Payable	YUMA COUNTY TREASURER	\$180.65		
89685	06/06/2019	Open			Accounts Payable	YUMA COUNTY WATER USERS	\$6.00		
89686	06/06/2019	Open			Accounts Payable	YUMA TRUCK PARTS	\$126.52		
89687	06/06/2019	Open			Accounts Payable	24-7 GET FIT SL, LLC	\$559.72		
89688	06/06/2019	Open			Accounts Payable	AIRGAS-WEST	\$1,361.40		
89689	06/06/2019	Open			Accounts Payable	ALSCO, INC	\$803.70		
89690	06/06/2019	Open			Accounts Payable	AMERICAN PAVEMENT PRESERVATION LLC	\$120,287.88		
89691	06/06/2019	Open			Accounts Payable	ARIZONA REFUSE SALES, LLC	\$5,405.52		
89692	06/06/2019	Open			Accounts Payable	ARIZONA STATE TREASURER	\$30,407.64		
89693	06/06/2019	Open			Accounts Payable	AUTOZONE STORES, INC	\$2,084.96		
89694	06/06/2019	Open			Accounts Payable	BIKE CYCLES	\$2,059.85		
89695	06/06/2019	Open			Accounts Payable	BILL ALEXANDER FORD	\$4,309.14		
89696	06/06/2019	Open			Accounts Payable	BLT READY MIX CONCRETE LLC	\$7,348.16		
89697	06/06/2019	Open			Accounts Payable	DESERT WATER	\$132.83		
89698	06/06/2019	Open			Accounts Payable	DNK PLUMBING SUPPLY	\$3,009.71		
89699	06/06/2019	Open			Accounts Payable	G&T LOCKSMITH AND SAFE CO.	\$860.38		
89700	06/06/2019	Open			Accounts Payable	GARCIA, JESUS	\$150.00		
89701	06/06/2019	Open			Accounts Payable	GUTIERREZ, JUAN, F	\$200.00		

Payment Register

From Payment Date: 6/3/2019 - To Payment Date: 6/6/2019

Number	Date	Status	Void Reason	Reconciled/ Voided Date	Source	Payee Name	Transaction Amount	Reconciled Amount	Difference
1BYPAYABLE - 1st BY Accounts Payable									
<u>Check</u>									
89608	06/05/2019	Open			Accounts Payable	ALONSO, FRANCIA	\$177.00		
89609	06/05/2019	Open			Accounts Payable	ALVAREZ, MIGUEL	\$145.00		
89610	06/05/2019	Open			Accounts Payable	CISNEROS, JOSE, LUIS	\$312.00		
89611	06/05/2019	Open			Accounts Payable	DE LA HOYA, TADEO	\$177.00		
89612	06/05/2019	Open			Accounts Payable	ENCINAS PARTIDA, JOSE, A	\$145.00		
89613	06/05/2019	Open			Accounts Payable	GOMEZ, BENJAMIN, J	\$145.00		
89614	06/05/2019	Open			Accounts Payable	GUEVARA, ALAN	\$145.00		
89615	06/05/2019	Open			Accounts Payable	PACHECO, ROMAN	\$312.00		
89616	06/05/2019	Open			Accounts Payable	REYNOSO, NIGEL	\$145.00		
89617	06/05/2019	Open			Accounts Payable	RUIZ, OSCAR	\$145.00		
89618	06/05/2019	Open			Accounts Payable	SANCHEZ, GERARDO	\$91.00		
89619	06/05/2019	Open			Accounts Payable	TAYLOR, JANET	\$312.00		
89620	06/05/2019	Open			Accounts Payable	VALENZUELA, JAIME	\$145.00		
89621	06/06/2019	Open			Accounts Payable	ROMO, OSCAR	\$45.88		
89622	06/06/2019	Open			Accounts Payable	CASAS, KARLA	\$35.00		
89623	06/06/2019	Open			Accounts Payable	CASTRO, MONICA	\$328.63		
89624	06/06/2019	Open			Accounts Payable	DNK PLUMBING SUPPLY	\$557.70		
89625	06/06/2019	Open			Accounts Payable	LEERS	\$537.10		
89626	06/06/2019	Open			Accounts Payable	LIRA, DELIA	\$45.00		
89627	06/06/2019	Open			Accounts Payable	MAGALLANES, CESAR	\$88.56		
89628	06/06/2019	Open			Accounts Payable	PEREZ, CRISTINA	\$50.00		
89629	06/06/2019	Open			Accounts Payable	RAMIREZ, ALEJANDRA	\$35.00		
89630	06/06/2019	Open			Accounts Payable	SABORI, MARIA	\$8.00		
89631	06/06/2019	Open			Accounts Payable	ALBERT HOLLER & ASSOCIATES	\$4,000.00		
89632	06/06/2019	Open			Accounts Payable	ALSCO, INC	\$595.37		
89633	06/06/2019	Open			Accounts Payable	AMBERLY'S PLACE	\$6,846.66		
89634	06/06/2019	Open			Accounts Payable	ANGEL'S TOWING SERVICE/AUTO SALES	\$75.00		
89635	06/06/2019	Open			Accounts Payable	APPLIED PRODUCTS GROUP LLC	\$10,337.22		
89636	06/06/2019	Open			Accounts Payable	ARIZONA WESTERN COLLEGE	\$964.72		
89637	06/06/2019	Open			Accounts Payable	AUTOZONE STORES, INC	\$374.16		
89638	06/06/2019	Open			Accounts Payable	BLT ASPHALT LLC	\$3,723.18		
89639	06/06/2019	Open			Accounts Payable	BOUND TREE MEDICAL, LLC.	\$1,964.41		
89640	06/06/2019	Open			Accounts Payable	BSN SPORTS	\$262.51		
89641	06/06/2019	Open			Accounts Payable	ELLIOTT AUTO SUPPLY CO INC	\$242.93		
89642	06/06/2019	Open			Accounts Payable	FISHER CHEVROLET - PARTS	\$97.57		
89643	06/06/2019	Open			Accounts Payable	LAWSON PRODUCTS INC.	\$841.35		
89644	06/06/2019	Open			Accounts Payable	LIMELIGHT CREATIVE GROUP	\$1,000.00		
89645	06/06/2019	Open			Accounts Payable	MATRIX DESIGN GROUP, INC	\$35,000.00		
89646	06/06/2019	Open			Accounts Payable	NAPA AUTO PARTS	\$300.00		
89647	06/06/2019	Open			Accounts Payable	O'REILLY AUTO PARTS	\$9.00		
89648	06/06/2019	Open			Accounts Payable	ON TRACK OVERHEAD DOORS	\$125.00		
89649	06/06/2019	Open			Accounts Payable	PG COMMUNICATION TECH LLC	\$1,474.32		
89650	06/06/2019	Open			Accounts Payable	PRECISION ELECTRIC CO. INC.	\$3,657.21		
89651	06/06/2019	Open			Accounts Payable	PUBLIC SAFETY CENTER, INC	\$454.83		
89652	06/06/2019	Open			Accounts Payable	PURCELL TIRE CO.	\$130.31		
89653	06/06/2019	Open			Accounts Payable	REDBURN TIRE COMPANY	\$2,139.71		
89654	06/06/2019	Open			Accounts Payable	SAN LUIS AZ NEWS	\$676.00		



Schedule B Pay Day Register

Pay Date Range 06/01/19 - 06/30/19
Pay Batch 201906M

Pay Batch 201906M Total

Employees in Pay Batch 7

Female Employees in Pay Batch 3

Hours Description	Hours	Gross	Withholdings and Deductions	Gross Base	Benefits	Gross Base
102 - SALARY	.0000	7,550.00	Gross	7,700.00	Dental Council	265.31 .00
806 - TELEPHONE STIPEND	.0000	150.00	Imputed Income		EODCRS - COUNCIL	108.00 .00
Total	0.0000	\$7,700.00	FEDERAL TAX WITHHOLDING	28.68 5,550.86	EODCRS - DISABILITY	2.26 .00
			SOCIAL SECURITY TAX	477.40 7,700.00	EODCRS/EORP LEGACY RATE	999.00 .00
			MEDICARE	111.67 7,700.00	Health Council	6,693.88 .00
			STATE WITHHOLDING	151.60 5,550.86	Retirement Council EORP	3,536.25 5,750.00
			Council Retirement EORP	588.50 5,750.00	Vision Council	76.37 .00
			Dental Council	147.98 .00	Total	\$11,681.07
			EODCRS - COUNCIL	144.00 .00	Workers' Comp	Gross Base
			EODCRS - DISABILITY	2.26 .00	MUNICIPAL/ TOWN/	134.77 7,700.00
			GARNISHMENT	220.86 .00	Total	\$134.77
			Medical Council	1,216.20 .00	Direct Deposits	Amount
			MISCELLANEOUS	55.00 .00	1st Bank Yuma	728.70
			Vision Council	50.20 .00	Chase Bank	688.14
			Net	\$4,505.65 ✓	Federal Credit Union	918.15
					Sunbank	1,005.58
					WASHINGTON FEDERAL	751.40
					Wells Fargo	413.68
					Total	\$4,505.65
					Check	\$0.00

Prepared by:
Debora Luna

Date:



Schedule C Pay Day Register

Pay Date Range 05/25/19 - 06/07/19

Pay Batch 201912

PSPRS POLICE DB RATE - TIER 2	1,224.39	10,509.80	BUILDING- NOC OPER BY	1,171.18	32,352.27
PSPRS POLICE DB RATE - TIER 3	1,680.94	16,910.96	BUS COMPANY AND DRIVERS	138.40	2,507.20
STANDARD LIFE ADDTNL	812.63	.00	CLERICAL OFFICE/ LIBRARY/	227.12	94,632.40
TRANSWESTERN MEXICAN	96.50	.00	Electrician	58.53	1,864.00
U.S. MEX DENTAL - EE &	634.80	.00	FIREFIGHTERS & DRIVERS	3,269.26	92,876.95
U.S. MEX DENTAL - EE &	63.48	.00	GARBAGE/ ASH/ REFUSE	265.88	4,254.10
UNITED WAY	14.00	.00	MUNICIPAL/ TOWN/	67.97	3,884.00
US & MEX DENTAL= FAMILY	581.24	.00	PARKS- NOC ALL EMPLOYEES	493.85	15,930.39
US & MEX HEALTH = C	6,141.80	.00	POLICE OFFICERS	4,552.31	103,933.99
US & MEX HEALTH = FAMILY	4,812.15	.00	RECREATION- ALL EMPLOYEES/	239.73	17,497.65
US & MEX HEALTH = SP	749.00	.00	SEWAGE DISPOSAL/ PLANT	670.13	19,480.58
VSP - VISION FAMILY	615.44	.00	Street or Road Construction	1,256.78	15,650.77
Net	<u>\$313,859.81</u> ✓		WATERWORKS OPERATIONS	551.35	15,889.16
			Total	<u>\$13,270.70</u>	

Direct Deposits	Amount
1st Bank Yuma	20,969.58
ACADEMY BANK	2,677.73
Bank of America	932.11
BANKCORP BANK	250.00
BBVA COMPASS	1,025.01
Charles Sch	200.00
Chase Bank	136,881.40
CHASE BANK CA	3,007.30
CHASE BANK MORGAN	1,749.56
chase centro	965.69
Federal Credit Union	38,503.86
FF CREDIT UNION	300.00
FIREFIGHTER FIRST CREDIT UNION	1,800.62
GREEN DOT BANK	1,168.11
National Bank	500.00
Navy Federal	10,553.61
NetSpend Corporation DD	120.00
NORTH ISLAND CREDIT UNION	992.14
Sunbank	1,986.27
USAA FEDERAL SAVING	1,184.70
WASHINGTON FEDERAL	878.36
Wells Fargo	60,841.20
WELLS FARGO ARKANSAS	2,119.31
Total	<u>\$289,606.56</u>

Check \$24,253.25

Prepared by:
Debora Luna

Date:

Payment Register

From Payment Date: 6/10/2019 - To Payment Date: 6/13/2019

Number	Date	Status	Void Reason	Reconciled/ Voided Date	Source	Payee Name	Transaction Amount	Reconciled Amount	Difference
89792	06/13/2019	Open			Accounts Payable	MACHADO, IVAN & AIXIA GUTIERREZ	\$700.00		
89793	06/13/2019	Open			Accounts Payable	MARKETING DESIGN AND PRINTING	\$1,771.56		
89794	06/13/2019	Open			Accounts Payable	RALPH VELEZ CONSULTING SERVICES	\$7,930.00		
89795	06/13/2019	Open			Accounts Payable	RODRIGUEZ, GUSTAVO	\$126.76		
89796	06/13/2019	Open			Accounts Payable	ROSALLES, MATIAS	\$838.42		
89797	06/13/2019	Open			Accounts Payable	RUIZ, JOSE	\$1,750.00		
89798	06/13/2019	Open			Accounts Payable	SAN LUIS OPTIMIST CLUB 800 ARIZONA	\$215.74		
89799	06/13/2019	Open			Accounts Payable	SILVA, JUAN, MANUEL	\$80.00		
89800	06/13/2019	Open			Accounts Payable	TAYLOR ENGINEERING PLLC	\$67,389.63		
89801	06/13/2019	Open			Accounts Payable	VALENZUELA, GABRIEL, A	\$42.00		
89802	06/13/2019	Open			Accounts Payable	YUMA PRINTING & GRAPHIC DEPT.	\$604.14		
89803	06/13/2019	Open			Accounts Payable	YUMA REGIONAL MEDICAL CENTER	\$860.42		
89804	06/13/2019	Open			Accounts Payable	YUMA SUN INC	\$11,652.09		
89805	06/13/2019	Open			Accounts Payable	A & H ELECTRIC	\$495.00		
Type Check Totals:							\$679,398.29		
1BYPAYABLE - 1st BY Accounts Payable Totals							\$679,398.29		

Checks	Status	Count	Transaction Amount	Reconciled Amount
	Open	97	\$679,398.29	\$0.00
	Reconciled	0	\$0.00	\$0.00
	Voided	0	\$0.00	\$0.00
	Stopped	0	\$0.00	\$0.00
	Total	97	\$679,398.29	\$0.00

All	Status	Count	Transaction Amount	Reconciled Amount
	Open	97	\$679,398.29	\$0.00
	Reconciled	0	\$0.00	\$0.00
	Voided	0	\$0.00	\$0.00
	Stopped	0	\$0.00	\$0.00
	Total	97	\$679,398.29	\$0.00

Grand Totals:

Checks	Status	Count	Transaction Amount	Reconciled Amount
	Open	97	\$679,398.29	\$0.00
	Reconciled	0	\$0.00	\$0.00
	Voided	0	\$0.00	\$0.00
	Stopped	0	\$0.00	\$0.00
	Total	97	\$679,398.29	\$0.00

All	Status	Count	Transaction Amount	Reconciled Amount
	Open	97	\$679,398.29	\$0.00
	Reconciled	0	\$0.00	\$0.00
	Voided	0	\$0.00	\$0.00
	Stopped	0	\$0.00	\$0.00
	Total	97	\$679,398.29	\$0.00

Angela Velez
6/13/19

Payment Register

From Payment Date: 6/10/2019 - To Payment Date: 6/13/2019

Number	Date	Status	Void Reason	Reconciled/ Voided Date	Source	Payee Name	Transaction Amount	Reconciled Amount	Difference
1BYPAYABLE - 1st BY Accounts Payable									
<u>Check</u>									
89709	06/12/2019	Open			Accounts Payable	CARRASCO, AFRICA	\$142.00		
89710	06/12/2019	Open			Accounts Payable	CASTRO, MONICA	\$64.00		
89711	06/12/2019	Open			Accounts Payable	CORNELIO, SONIA	\$226.00		
89712	06/12/2019	Open			Accounts Payable	CORTES, CARLOS	\$64.00		
89713	06/12/2019	Open			Accounts Payable	DUENAS, DEREK	\$273.00		
89714	06/12/2019	Open			Accounts Payable	ECHAVARRIA, NOHEMY	\$192.00		
89715	06/12/2019	Open			Accounts Payable	GUZMAN, JOSE, A	\$91.00		
89716	06/12/2019	Open			Accounts Payable	JOUANNE DE ENCINAS, ROULA	\$64.00		
89717	06/12/2019	Open			Accounts Payable	JUAREZ, EDGAR	\$167.00		
89718	06/12/2019	Open			Accounts Payable	LOPEZ, MELISSA	\$226.00		
89719	06/12/2019	Open			Accounts Payable	LUNA, DEBORA	\$64.00		
89720	06/12/2019	Open			Accounts Payable	PONCE, JOSE	\$142.00		
89721	06/12/2019	Open			Accounts Payable	RAMIREZ, MIGUEL	\$64.00		
89722	06/12/2019	Open			Accounts Payable	ROSALES, MATIAS	\$167.00		
89723	06/13/2019	Open			Accounts Payable	CENTURYLINK	\$169.26		
89724	06/13/2019	Open			Accounts Payable	CORTES, CARLOS	\$366.35		
89725	06/13/2019	Open			Accounts Payable	TOSHIBA FINANCIAL SERVICES	\$1,639.68		
89726	06/13/2019	Open			Accounts Payable	US BANK EQUIPMENT FINANCE	\$6,376.14		
89727	06/13/2019	Open			Accounts Payable	YUMA OFFICE EQUIPMENT	\$3,904.23		
89728	06/13/2019	Open			Accounts Payable	4 IMPRINT	\$6,415.12		
89729	06/13/2019	Open			Accounts Payable	AGUILAR, DANIEL	\$8.00		
89730	06/13/2019	Open			Accounts Payable	ARIZONA STATE LAND DEPARTMENT	\$350,000.00		
89731	06/13/2019	Open			Accounts Payable	BORDER GYM FITNESS LLC	\$374.00		
89732	06/13/2019	Open			Accounts Payable	BRIDGET'S GIFT	\$410.00		
89733	06/13/2019	Open			Accounts Payable	CDWG	\$14,567.36		
89734	06/13/2019	Open			Accounts Payable	CENTURYLINK	\$1,327.81		
89735	06/13/2019	Open			Accounts Payable	CENTURYLINK	\$280.22		
89736	06/13/2019	Open			Accounts Payable	CITY OF SURPRISE	\$200.00		
89737	06/13/2019	Open			Accounts Payable	CUEVAS, CHRISTIAN	\$50.00		
89738	06/13/2019	Open			Accounts Payable	DANA-KEPNER COMPANY INC.	\$33,342.00		
89739	06/13/2019	Open			Accounts Payable	DESERT DOCUMENT SHREDDERS, LLC	\$90.00		
89740	06/13/2019	Open			Accounts Payable	DIAMONDBACK POLICE SUPPLY, INC.	\$4,125.97		
89741	06/13/2019	Open			Accounts Payable	DON CHALMERS FORD INC	\$14,040.44		
89742	06/13/2019	Open			Accounts Payable	EMPIRE MACHINERY	\$966.00		
89743	06/13/2019	Open			Accounts Payable	FIREFIGHTER SELECTION, INC.	\$500.00		
89744	06/13/2019	Open			Accounts Payable	FISHER CHEVROLET - PARTS	\$1,991.35		
89745	06/13/2019	Open			Accounts Payable	FISHER CHRYSLER	\$128.93		
89746	06/13/2019	Open			Accounts Payable	FOUNDATION OF YUMA REGIONAL MEDICAL CENTER	\$410.00		
89747	06/13/2019	Open			Accounts Payable	FRESH TERRA SERVICES LLC	\$7,941.00		
89748	06/13/2019	Open			Accounts Payable	GUARDIAN MEDICAL PRODUCTS, LLC	\$1,958.08		
89749	06/13/2019	Open			Accounts Payable	HANSBERGER REGRIGERATION & ELECTRIC CO	\$748.00		
89750	06/13/2019	Open			Accounts Payable	HERNANDEZ, ALEX , A	\$57.00		

Payment Register

From Payment Date: 6/10/2019 - To Payment Date: 6/13/2019

Number	Date	Status	Void Reason	Reconciled/ Voided Date	Source	Payee Name	Transaction Amount	Reconciled Amount	Difference
89751	06/13/2019	Open			Accounts Payable	HOPE BRIGADE	\$410.00		
89752	06/13/2019	Open			Accounts Payable	IBARRA TALAMANTES, HILDA	\$3,000.00		
89753	06/13/2019	Open			Accounts Payable	IRELAND INC	\$3,960.00		
89754	06/13/2019	Open			Accounts Payable	LANGUAGE CONNECTION	\$30.25		
89755	06/13/2019	Open			Accounts Payable	LOGICAL CONCEPTS, INC	\$611.16		
89756	06/13/2019	Open			Accounts Payable	MCNEECE BROS. OIL COMPANY, INC	\$38,574.13		
89757	06/13/2019	Open			Accounts Payable	MENDEZ ROBLES, NAZZER, O	\$4,451.79		
89758	06/13/2019	Open			Accounts Payable	PURCELL TIRE CO.	\$80.46		
89759	06/13/2019	Open			Accounts Payable	QUINONES TIRE LLC	\$9.00		
89760	06/13/2019	Open			Accounts Payable	QUINONEZ, FRANCISCO	\$75.00		
89761	06/13/2019	Open			Accounts Payable	RAMON MOSQUEDA	\$60.00		
89762	06/13/2019	Open			Accounts Payable	SAFETYFILE, INC.	\$3,579.00		
89763	06/13/2019	Open			Accounts Payable	SAN LUIS WALK IN CLINIC, INC	\$525.00		
89764	06/13/2019	Open			Accounts Payable	SHRM	\$189.00		
89765	06/13/2019	Open			Accounts Payable	SIGN MASTERS	\$7,012.02		
89766	06/13/2019	Open			Accounts Payable	THE LAW OFFICES OF RYAN C. HENGL ESQ. P.L.C.	\$2,600.00		
89767	06/13/2019	Open			Accounts Payable	TRI-TECH FORENSICS INC.	\$817.59		
89768	06/13/2019	Open			Accounts Payable	USA BLUE BOOK	\$238.65		
89769	06/13/2019	Open			Accounts Payable	VERIZON WIRELESS MESSAGING SVC	\$10,245.75		
89770	06/13/2019	Open			Accounts Payable	YUMA COUNTY HUMANE SOCIETY	\$4,166.67		
89771	06/13/2019	Open			Accounts Payable	YUMA REGIONAL MEDICAL CENTER	\$2,800.00		
89772	06/13/2019	Open			Accounts Payable	CALIFORNIA STATE DISBURSEMENT UNIT	\$252.91		
89773	06/13/2019	Open			Accounts Payable	CHARGO PA, GURSTEL	\$26.95		
89774	06/13/2019	Open			Accounts Payable	FOP/ALC	\$300.00		
89775	06/13/2019	Open			Accounts Payable	INTERNAL REVENUE SERVICE	\$100.00		
89776	06/13/2019	Open			Accounts Payable	INTERNAL REVENUE SERVICE	\$220.86		
89777	06/13/2019	Open			Accounts Payable	SAN LUIS POLICE OFFICERS ASSOC	\$405.00		
89778	06/13/2019	Open			Accounts Payable	SUPPORT PAYMENT CLEARINGHOUSE	\$4,178.49		
89779	06/13/2019	Open			Accounts Payable	UNITED WAY OF YUMA COUNTY INC.	\$14.00		
89780	06/13/2019	Open			Accounts Payable	UNITED YUMA FIRE FIGHTERS ASSOC	\$75.50		
89781	06/13/2019	Open			Accounts Payable	UNITED YUMA FIRE FIGHTERS- IAFF	\$800.00		
89782	06/13/2019	Open			Accounts Payable	AMERICAN TRAINCO LLC	\$2,200.00		
89783	06/13/2019	Open			Accounts Payable	CARDENAS, JUAN, A	\$82.00		
89784	06/13/2019	Open			Accounts Payable	DESERT VALLEY SERVICES, INC	\$365.08		
89785	06/13/2019	Open			Accounts Payable	EMAZON, JESUS	\$120.00		
89786	06/13/2019	Open			Accounts Payable	FISHER CHEVROLET - PARTS	\$33,405.90		
89787	06/13/2019	Open			Accounts Payable	GOMEZ-DOMINGUEZ, FRANCISCO	\$2,494.41		
89788	06/13/2019	Open			Accounts Payable	JUAREZ, EDGAR	\$772.26		
89789	06/13/2019	Open			Accounts Payable	LA PEQUENA	\$1,164.00		
89790	06/13/2019	Open			Accounts Payable	LOPEZ RIOS, JOSE , A	\$70.00		
89791	06/13/2019	Open			Accounts Payable	LUNA, JESUS ENRIQUE	\$126.76		



AGENDA ITEM REVIEW FORM

Special City Council Meeting

4.C.

Meeting Date: 06/25/2019

Department Head: Richard Jessup, Chief of Police, Police Department

Submitted By: Miguel Alvarez, Lieutenant, Police Department

Action Requested: Motion

ITEM:

Discussion and possible action on any and all matters regarding the purchase of 17 Mobile Data Computers (MDCs) with associated hardware to be purchased using funding approved by an Intergovernmental Agreement under Subrecipient Agreement Number 180436-02, Operation Stonegarden Grant Program Award. **(Richard Jessup, Chief of Police)**

SUMMARY:

The City of San Luis Police Department has been awarded \$60,000.00 for 17 Mobile Data Computers (MDCs) under the Fiscal Year 2019 Operation Stonegarden Program Award under Subrecipient Agreement Number 180436-02.

The Mobile Data Computers will be specifically used to support Operation Stonegarden. During the times of the operation, officers will maintain vigilance in high traffic areas along the border and employ methods to assist in deterring illicit cross-border traffic in areas predetermined and identified by the City of San Luis Police Department to include areas between the United States-Mexico border, Cesar Chavez Boulevard, Avenue B, Avenue H, the levee and County 21½, Highway 95 and Arizona 195.

The San Luis Police Department is requesting to purchase 17 Mobile Data Computers and hardware from Mobile Concepts Technology (MCT) for the amount of \$58,998.50. Mobile Concepts Technology is under the National Association of State Procurement Officers Contract #ADSP018-183112, which will be in accordance with the San Luis City Code-Purchasing §36.09, Cooperative Purchasing. The purchase of the Mobile Data Computers will take place after June 30th, 2019.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE THE PURCHASE OF 17 MOBILE DATA COMPUTERS AND HARDWARE FOR \$60,000.00 FROM THE STONEGARDEN GRANT AS PRESENTED.

N/A

Fiscal Impact

IS THERE FISCAL IMPACT ASSOCIATED WITH THIS ITEM:	Yes
CITY/STATE/FEDERAL FUNDS:	Federal
TOTAL:	\$58,998.50
BUDGETED AMOUNT:	\$60,000.00 FY2020
AVAILABLE AMOUNT TO TRANSFER:	N/A

ACCT NAME & GL#/REMAINING BALANCE BEFORE PURCHASE: 250-181-90000 Special
Revenue-Public Safety, PD:
Capital Outlay/Equipment
\$60,000 FY 2020

FISCAL IMPACT STATEMENT (IF THIS IS A BUDGET TRANSFER, YOU MUST ATTACH THE BUDGET ADJUSTMENT FORM):

The fiscal impact to the city is temporary because the Arizona Department of Homeland Security grant will reimburse the entire purchase cost of \$58,998.50 for the equipment.

Account number 250-181-90000 Special Revenue-Public Safety, PD: Capital Outlay/Equipment has a zero (0) balance this fiscal year. In the 2019-2020 Fiscal Year, the city will allocate \$60,000.00 to the account under the 2019-2020 budget. The Police Department will purchase the equipment in the 2019-2020 Fiscal Year, and the grant will reimburse the Police Department's outlay of \$58,998.50.

Attachments

Award Letter
Subrecipient Agreement
Quote



State of Arizona

Department of Homeland Security



Governor Douglas A. Ducey

Director Gilbert M. Orrantia

December 27, 2018

Chief Richard Jessup
San Luis Police Department
PO Box 3720
San Luis, AZ 85349

Subject: FFY 2018 Operation Stonegarden Grant Program Award
Subrecipient Agreement Number: **180436-02**
Project Title: **OPSG Equipment**

Dear Chief Jessup:

The OPSG Budget/Narrative Application that your agency submitted to the Arizona Department of Homeland Security (AZDOHS) for consideration under the Operation Stonegarden Grant Program (OPSG) has been awarded. The project titled "**OPSG Equipment**" has been funded under the Operation Stonegarden Grant Program for **\$60,000**. The grant performance period is **January 1, 2019 through December 31, 2019**. This grant program is part of the U.S. Department of Homeland Security Grant Program and specifically is awarded under CFDA #97.067 (Catalog of Federal Domestic Assistance). The FFY 2018 federal award date as indicated in the U.S. DHS award package is 9/01/2018 with a total amount of funding of \$25,580,000. The Federal Award Identification Number is EMW-2018-SS-00004-S01.

To initiate the award process, the following action items must be completed, signed and returned to AZDOHS. Go to www.azdohs.gov, Grant Programs, Operation Stonegarden Grant Program, Grant Award Information, FFY 2018:

1. Two Subrecipient Agreements - Download **two** original OPSG Subrecipient Agreements (**NOTE**: they are specific to the "Overtime/Mileage" and "Equipment" grants):
 - a. Overtime/Mileage Subrecipient Agreement for an Overtime/Mileage grant
 - b. Equipment Subrecipient Agreement for an Equipment grant
2. Financial Forms - Download this Excel document
3. NIMS Compliance Certification - Download this Excel document
4. OPSG Budget Detail (enclosed)
5. Environmental and Historic Preservation (EHP) required documentation (if applicable, see enclosed EHP Designation Letter).

Hard copies of the Subrecipient Agreements, Financial Forms, and the NIMS Compliance Certification will **not** be mailed to you. These items must be completed and on file at AZDOHS in order for your agency to be eligible for reimbursement. **If all documentation listed in numbers 1, 2, 3, 4 and 5 above (if applicable) is not signed and received by AZDOHS on or before April 30, 2019 this award is rescinded and the funds will be reallocated.**

If your project requires an Environmental and Historic Preservation (EHP) review, this must be completed, submitted and approved by FEMA/AZDOHS prior to any obligation/expenditure of funds. Additionally, all actions associated with this project must be completed, invoiced and received by the end of the period of performance. Reimbursements are limited to approved quantities and funding thresholds. You will not be reimbursed for quantities in excess of what you have been authorized to purchase. AZDOHS reserves the right to request additional documentation at any time.

If you should have any questions, please do not hesitate to contact your Strategic Planner. Congratulations on your Operation Stonegarden Grant Program award.

Sincerely,

Gilbert M. Orrantia
Director

Cc: Lt. Miguel Alvarez

Enclosures: OPSG Budget Detail, EHP Designation Letter

FY 2018 Operation Stonegarden Grant Program
Budget Detail - Equipment
Agency: San Luis Police Department
Grant#: 180436-02

The signatures below verify the submission/approval process. All parties signify that all aspects of this project are allowable, reasonable and justifiable in accordance with published federal grant guidelines. Subrecipient agrees to the funding shown here:

EQUIPMENT

EQUIPMENT	AEL	QUANTITY	COST/UNIT	TOTAL COST	TOTAL AWARD
Mobile Data Computer	04HW-01-MOBL	12	\$5,000	\$60,000	
					\$60,000

Project Point of Contact

Print Name

Signature

Date

Strategic Planner or
Assistant Director Planning & Preparedness

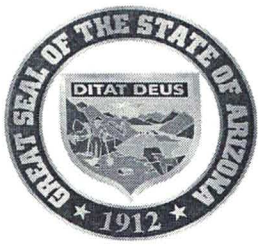
William D. Seltzer

Print Name

Signature

Date

This form is to be signed and returned.



Governor Douglas A. Ducey

FFY 2018

Dear OPSG Stakeholder:

The project that your agency submitted to the Arizona Department of Homeland Security (AZDOHS) for consideration under the Operation Stonegarden Grant Program has been awarded.

Please be advised, all projects require an Environmental and Historic Preservation review. Your project has been reviewed and it has been determined to have no potential impact to environmental or historic concerns. No further EHP review is required unless you modify the project and it is approved by AZDOHS. If you need further clarification please contact Michael Stidham at (602) 542-7041 or mstidham@azdohs.gov with AZDOHS for further information regarding the EHP specific requirements for your award.

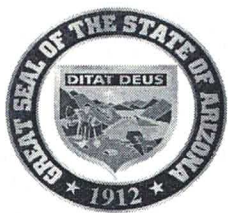
As stated in the subrecipient agreement:

The subrecipient shall comply with Federal EHP regulations, laws and Executive Orders as applicable. Subrecipients proposing projects that have the potential to impact the environment, including but not limited to construction of communication towers, modification or renovation of existing buildings, structures and facilities, or new construction including replacement of facilities, must participate in the DHS/FEMA EHP review process. The EHP review process involves the submission of a detailed project description that explains the goals and objectives of the proposed project along with supporting documentation so that DHS/FEMA may determine whether the proposed project has the potential to impact environmental resources and/or historic properties. In some cases, DHS/FEMA is also required to consult with other regulatory agencies and the public in order to complete the review process. The EHP review process must be completed before funds are released to carry out the proposed project. DHS/FEMA will not fund projects that are initiated without the required EHP review.

Additionally, all recipients are required to comply with DHS/FEMA EHP Policy Guidance. This EHP Policy Guidance can be found in FP 108-023-1, Environmental Planning and Historic Preservation Policy Guidance, and FP 108.24.4, Environmental Planning and Historical Preservation Policy.



Director Gilbert M. Orrantia



State of Arizona Department of Homeland Security



Governor Douglas A. Ducey

Director Gilbert M. Orrantia

December 27, 2018

Chief Richard Jessup
San Luis Police Department
PO Box 3720
San Luis, AZ 85349

Subject: FFY 2018 Operation Stonegarden Grant Program Award
Subrecipient Agreement Number: **180436-02**
Project Title: **OPSG Equipment**

Dear Chief Jessup:

The OPSG Budget/Narrative Application that your agency submitted to the Arizona Department of Homeland Security (AZDOHS) for consideration under the Operation Stonegarden Grant Program (OPSG) has been awarded. The project titled "**OPSG Equipment**" has been funded under the Operation Stonegarden Grant Program for **\$60,000**. The grant performance period is **January 1, 2019 through December 31, 2019**. This grant program is part of the U.S. Department of Homeland Security Grant Program and specifically is awarded under CFDA #97.067 (Catalog of Federal Domestic Assistance). The FFY 2018 federal award date as indicated in the U.S. DHS award package is 9/01/2018 with a total amount of funding of \$25,580,000. The Federal Award Identification Number is EMW-2018-SS-00004-S01.

To initiate the award process, the following action items must be completed, signed and returned to AZDOHS. Go to www.azdohs.gov, Grant Programs, Operation Stonegarden Grant Program, Grant Award Information, FFY 2018:

1. Two Subrecipient Agreements - Download **two** original OPSG Subrecipient Agreements (**NOTE**: they are specific to the "Overtime/Mileage" and "Equipment" grants):
 - a. Overtime/Mileage Subrecipient Agreement for an Overtime/Mileage grant
 - b. Equipment Subrecipient Agreement for an Equipment grant
2. Financial Forms - Download this Excel document
3. NIMS Compliance Certification - Download this Excel document
4. OPSG Budget Detail (enclosed)
5. Environmental and Historic Preservation (EHP) required documentation (if applicable, see enclosed EHP Designation Letter).

Hard copies of the Subrecipient Agreements, Financial Forms, and the NIMS Compliance Certification will **not** be mailed to you. These items must be completed and on file at AZDOHS in order for your agency to be eligible for reimbursement. **If all documentation listed in numbers 1, 2, 3, 4 and 5 above (if applicable) is not signed and received by AZDOHS on or before April 30, 2019 this award is rescinded and the funds will be reallocated.**

If your project requires an Environmental and Historic Preservation (EHP) review, this must be completed, submitted and approved by FEMA/AZDOHS prior to any obligation/expenditure of funds. Additionally, all actions associated with this project must be completed, invoiced and received by the end of the period of performance. Reimbursements are limited to approved quantities and funding thresholds. You will not be reimbursed for quantities in excess of what you have been authorized to purchase. AZDOHS reserves the right to request additional documentation at any time.

If you should have any questions, please do not hesitate to contact your Strategic Planner. Congratulations on your Operation Stonegarden Grant Program award.

Sincerely,

Gilbert M. Orrantia
Director

Cc: Lt. Miguel Alvarez

Enclosures: OPSG Budget Detail, EHP Designation Letter

**SUBRECIPIENT AGREEMENT
OPERATION STONEGARDEN GRANT PROGRAM
EQUIPMENT**

18-AZDOHS-OPSG-_____

(Enter Subrecipient Agreement number above (e.g., 180XXX-XX))

Between

**The Arizona Department of Homeland Security
And**

(Enter the name of the Subrecipient Agency above)

DUNS Number _____

(Enter the DUNS number above)

WHEREAS, A.R.S. section 41-4254 charges the Arizona Department of Homeland Security (AZDOHS) with the responsibility of administering funds.

THEREFORE, it is agreed that the AZDOHS shall provide funding to the

(Subrecipient) for services under the terms of this Agreement (the "Agreement").

I. PURPOSE OF AGREEMENT

The purpose of this Agreement is to specify the rights and responsibilities of AZDOHS in administering the distribution of homeland security grant funds to the Subrecipient, and to specify the rights and responsibilities of the Subrecipient as the recipient of these funds.

II. PERIOD OF PERFORMANCE, TERMINATION AND AMENDMENTS

This Agreement shall become effective on **January 1, 2019** and shall terminate on **December 31, 2019**. The obligations of the Subrecipient as described herein will survive termination of this agreement.

III. DESCRIPTION OF SERVICES

The Subrecipient shall provide the services for AZDOHS as set forth in writing in Subrecipient's grant application titled: "**OPSG Equipment**" and funded at \$ _____ (as may have been modified by the award letter).
(Enter funded award amount above)

IV. MANNER OF FINANCING

The AZDOHS shall under the U.S. Department of Homeland Security grant # EMW-2018-SS-00004-S01 and CFDA #97.067:

- a) Provide up to \$ _____ to the Subrecipient for services provided under Paragraph III.
- b) Payment made by the AZDOHS to the Subrecipient shall be on a reimbursement basis only and is conditioned upon receipt of proof of payment and applicable, accurate and complete reimbursement documents, as deemed necessary by the AZDOHS, to be submitted by the Subrecipient. A listing of acceptable documentation can be found at www.azdohs.gov.

Payments will be contingent upon receipt of all reporting requirements of the Subrecipient under this Agreement.

V. FISCAL RESPONSIBILITY

It is understood and agreed that the total amount of the funds used under this Agreement shall be used only for the project as described in the application and award documentation. Therefore, should the project not be completed, the subrecipient shall reimburse said funds directly to the AZDOHS immediately. If the project is completed at a lower cost than the original budget called for, the amount reimbursed to the subrecipient shall be for only the amount of dollars actually spent by the subrecipient in accordance with the approved application. For any funds received under this Agreement for which expenditure is disallowed by an audit exemption or otherwise by the AZDOHS, the State, or Federal government, the Subrecipient shall reimburse said funds directly to the AZDOHS immediately.

VI. FINANCIAL AUDIT/PROGRAMMATIC MONITORING

The Subrecipient agrees to comply with the record-keeping requirements and other requirements of A.R.S. section 35-214 and section 35-215.

- a) In addition, in compliance with the Federal Single Audit Act (31 U.S.C. part 7501-7507), as amended by the Single Audit Act Amendments of 1996 (P.L. 104 to 156), the Subrecipient must have a Single Audit or program specific audit conducted in accordance with 2 CFR 200 (Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards) if the Subrecipient expends more than \$750,000 from Federal awards in its previous fiscal year. If the Subrecipient has expended more than \$750,000 in Federal dollars, a copy of the Subrecipient's single audit or program specific audit report for the previous fiscal year and subsequent fiscal years that fall within the period of performance is due annually to AZDOHS within nine (9) months of the Subrecipient's fiscal year end.
- b) Failure to comply with any requirements imposed as a result of an audit will suspend reimbursement by AZDOHS to the Subrecipient until the Subrecipient is in compliance with all such requirements. Additionally, the Subrecipient will not be eligible for any new awards until the Subrecipient is in compliance with all such requirements.
- c) Subrecipients who do not expend more than \$750,000 in Federal dollars in the previous fiscal year and subsequent fiscal years that fall within the period of performance must submit to AZDOHS via audits@azdohs.gov, a statement stating they do not meet the threshold and therefore do not have to complete a single audit or program specific audit.
- d) Subrecipient will be monitored periodically by AZDOHS, both programmatically and financially, to ensure that the project goals, objectives, performance requirements, timelines, milestone completion, budgets, and other related program criteria are being met. Monitoring will be accomplished through a combination of office-based reviews and on-site monitoring visits. Monitoring can involve aspects of the work involved under this Agreement including but not limited to the review and analysis of financial, programmatic, equipment, performance, and administrative issues relative to each program and will identify areas where technical assistance and other support may be needed. Subrecipient shall participate in and cooperate with all such monitoring by AZDOHS, and shall provide access to all personnel, documents, and other records as may be requested from time to time by AZDOHS. Subrecipient also shall comply with all requests of AZDOHS that AZDOHS deems necessary to assure the parties' compliance with their obligations under this Agreement.

VII. APPLICABLE REGULATIONS

The Subrecipient must comply with the applicable Notice of Funding Opportunity (NOFO), Office of Management and Budget Code of Federal Regulations (CFR) 2 CFR 200: Uniform Guidance.

The NOFO for this program is hereby incorporated into your award agreement by reference. By accepting this award, the Subrecipient agrees that all allocation and use of funds under this grant will be in accordance with the requirements contained in the NOFO.

Davis Bacon Act

HSGP Program subrecipients using funds for construction projects must comply with the *Davis-Bacon Act* (40 U.S.C. 3141 *et seq.*). Subrecipients must obtain written approval from AZDOHS prior to use of any HSGP funds for construction or renovation. Subrecipients must ensure that their contractors or subcontractors for construction projects pay workers no less than the prevailing wages for laborers and mechanics employed on projects of a character similar to the contract work in the civil subdivision of the state in which the work is to be performed. Additional information regarding compliance with the *Davis-Bacon Act*, including Department of Labor (DOL) wage determinations, is available from the following website <http://www.dol.gov/compliance/laws/comp-dbra.htm>.

Insurance Coverage

The Subrecipient affirms the organization maintain insurance coverage as described in 2 CFR 200.310. The non-Federal (Subrecipient) entity must, at a minimum, provide the equivalent insurance coverage for real property and equipment acquired or improved with Federal funds as provided to property owned by the non-Federal entity. Federally-owned property need not be insured unless required by the terms and conditions of the Federal award.

National Incident Management System (NIMS)

The Subrecipient agrees to remain in compliance with National Incident Management System (NIMS) implementation initiatives as outlined in the applicable NOFO.

Environmental Planning and Historic Preservation

The Subrecipient shall comply with Federal, State and Local environmental and historical preservation (EHP) regulations, laws and Executive Orders as applicable. Subrecipients proposing projects that have the potential to impact the environment, including but not limited to construction of communication towers, modification or renovation of existing buildings, structures and facilities, or new construction including replacement of facilities, must participate in the Department of Homeland Security (DHS)/Federal Emergency Management Agency (FEMA) EHP review process. The EHP review process involves the submission of a detailed project description that explains the goals and objectives of the proposed project along with supporting documentation so that DHS/FEMA may determine whether the proposed project has the potential to impact environmental resources and/or historic properties. In some cases, DHS/FEMA is also required to consult with other regulatory agencies and the public in order to complete the review process. The EHP review process must be completed before funds are released to carry out the proposed project. If ground disturbing activities occur during project implementation, the Subrecipient must ensure monitoring of ground disturbance and if any archeological resources are discovered, the Subrecipient shall immediately cease construction in that area and notify FEMA, AZDOHS and the appropriate State Historic Preservation Office. DHS/FEMA will not fund projects that are initiated without the required EHP review.

Additionally, all recipients are required to comply with DHS/FEMA EHP Policy Guidance. This EHP Policy Guidance can be found in FP 108-023-1, Environmental Planning and Historic Preservation Policy Guidance.

In addition to the above mentioned guidance documents, the following provisions must be adhered to:

Consultants/Trainers/Training Providers

Invoices for consultants/trainers/training providers must include at a minimum: a description of services; dates of services; number of hours for services performed; rate charged for services; and, the total cost of services performed. Consultant/trainer/training provider costs must be within the prevailing rates; must be obtained under consistent treatment with the procurement policies of the Subrecipient and 2 CFR 200; and shall not exceed the maximum of \$450 per day per consultant/trainer/training provider unless prior written approval is granted by the AZDOHS. This includes internal personnel hired on backfill/overtime to deliver training. In addition to the per day \$450 maximum amount, the consultant/trainer/training provider may be reimbursed reasonable travel, lodging, meal and incidental expenses not to exceed the State rate. Itemized receipts are required for lodging and travel reimbursements. The Subrecipient will not be reimbursed costs other than travel, lodging, meals and incidentals on travel days for consultants/trainers/training providers. See Travel Costs below.

Contractors/Subcontractors

The Subrecipient may enter into written subcontract(s) for performance of certain of its functions under the Agreement in accordance with terms established in 2 CFR 200 and the applicable NOFO. The Subrecipient agrees and understands that no subcontract that the Subrecipient enters into with respect to performance under this Agreement shall in any way relieve the Subrecipient of any responsibilities for performance of its duties. The Subrecipient shall give the AZDOHS immediate notice in writing by certified mail of any action or suit filed and prompt notice of any claim made against the Subrecipient by any subcontractor or vendor which, in the opinion of the Subrecipient, may result in litigation related in any way to this Agreement.

Travel Costs

All grant funds expended for travel, lodging, meals and incidentals must be consistent with the subrecipient's policies and procedures, as well as the State of Arizona Accounting Manual (SAAM). These policies must be applied uniformly to both federally financed and other activities of the agency. AZDOHS will reimburse at the most restrictive allowability and rate. At no time will the Subrecipient's reimbursement(s) exceed the State rate established by the Arizona Department of Administration, General Accounting Office Travel Policies: <https://gao.az.gov>.

Procurement

The Subrecipient shall comply with its own procurement rules/policies and must also comply with Federal procurement rules/policies and all Arizona state procurement code provisions and rules. The Federal intent is that all Homeland Security Funds are awarded competitively. The Subrecipient shall not enter into a Noncompetitive (Sole or Single Source) Procurement Agreement, unless prior written approval is granted by the AZDOHS via the Noncompetitive Procurement Request Form. The Noncompetitive Procurement Request Form and instructions are located on the AZDOHS website: www.azdohs.gov.

Training and Exercise

The Subrecipient agrees that any grant funds used for training and exercise must be in compliance with the applicable NOFO. All training must be included and approved in your application and/or approved through the DEMA/AZDOHS training request process prior to execution of training contract(s). All exercises must utilize and comply with the FEMA Homeland Security Exercise and Evaluation Program (HSEEP) guidance for exercise design, development, conduct, evaluation and reporting. The Subrecipient agrees to:

- a) Submit an exercise summary and attendance/sign-in roster to AZDOHS with all related reimbursement requests.
- b) Email the After Action Report/Improvement Plan (AAR/IP) to the local County Emergency Manager, the AZDOHS Strategic Planner, and the Arizona Department of Military Affairs

(DEMA) Exercise Branch within 90 days of completion of an exercise or as prescribed by the most current HSEEP guidance.

Communications Equipment

All Land Mobile Radio equipment purchased with Homeland Security funds is required to comply with the following:

- a) P25 standards;
- b) SAFECOM Guidance;
- c) Land Mobile Radio Minimum Equipment Standards as approved by the Statewide Interoperability Executive Committee (SIEC); and
- d) Arizona's State Interoperable Priority Programming Guide also as approved by the SIEC.

Nonsupplanting Agreement

The Subrecipient shall not use funds received under this Agreement to supplant Federal, State, Tribal or Local funds or other resources that would otherwise have been made available for this program/project. The Subrecipient may be required to demonstrate and document that a reduction in non-Federal resources occurred for reasons other than the receipt of expected receipt of Federal funds. Further, if a position created by a grant is filled from within, the vacancy created by this action must be filled within thirty (30) days. If the vacancy is not filled within thirty (30) days, the Subrecipient must stop charging the grant for the new position. Upon filling the vacancy, the Subrecipient may resume charging for the grant position.

E-Verify

Compliance requirements for A.R.S. section 41-4401—immigration laws and E-Verify requirement.

- a) The Subrecipient warrants its compliance with all State and Federal immigration laws and regulations relating to its employees and to employees of any contractor or subcontractor retained through Subrecipient to provide goods or services related to this Agreement, including but not limited to A.R.S. section 23-214, Subsection A (that subsection reads: "After December 31, 2007, every employer, after hiring an employee, shall verify the employment eligibility of the employee through the E-Verify program").
- b) A breach of a warranty by Subrecipient regarding compliance with immigration laws and regulations shall be deemed a material breach of this Agreement and the Subrecipient may be subject to penalties to be determined at AZDOHS's discretion, up to and including termination of this Agreement.
- c) The AZDOHS retains the legal right to inspect the papers of any Subrecipient employee who works on the Agreement, and to those of any employee of any contractor or subcontractor retained through Subrecipient to provide goods or services related to this Agreement, to ensure that the Subrecipient is complying with the warranty under paragraph (a) above.

Property Control

Effective control and accountability must be maintained by Subrecipient for all property/equipment purchased under this Agreement. The Subrecipient must adequately safeguard all such property/equipment and must assure that it is used for authorized purposes as described in the NOFO, grant application, and Code of Federal Regulations 2 CFR 200. The Subrecipient shall exercise caution in the use, maintenance, protection and preservation of such property.

- a) Property/equipment shall be used by the Subrecipient in the program or project for which it was acquired as long as needed, whether or not the program or project continues to be supported by federal grant funds. Subrecipient is required to maintain and utilize equipment as outlined in 2 CFR 200.313 - Equipment. Any loss, damage, or theft shall be investigated and reported to the AZDOHS. Any equipment lost, damaged or stolen shall be replaced by

the Subrecipient at the Subrecipient's expense and an updated Property Control Form submitted to AZDOHS.

- b) Nonexpendable Property/Equipment and Capital Assets:
 - a. Nonexpendable Property/Equipment is property which has a continuing use, is not consumed in use, is of a durable nature with an expected service life of one or more years, has an acquisition cost of \$5,000 (Five Thousand Dollars) or more, and does not become a fixture or lose its identity as a component of other equipment or systems.
 - b. A Capital Asset is any personal or real property, or fixture that has an acquisition cost of \$5,000 (Five Thousand Dollars) or more per unit and a useful life of more than one year.
- c) A Property Control Form (if applicable) shall be maintained for the entire scope of the program or project for which property was acquired through the end of its useful life and/or disposition. All Nonexpendable Property and Capital Assets must be included on the Property Control Form. The Subrecipient shall provide AZDOHS a copy of the Property Control Form with the final quarterly programmatic report. The Property Control Form can be located at www.azdohs.gov. The Subrecipient agrees to be subject to equipment monitoring and auditing by state or federal authorized representatives to verify information.
- d) A physical inventory of Nonexpendable Property/Equipment and Capital Assets must be taken and the results reconciled with the Property Control Form at least once every two years.
 - a. A control system must be developed to ensure adequate safeguards to prevent loss, damage, or theft of the property. Any loss, damage, or theft shall be investigated and reported to AZDOHS.
 - b. Adequate maintenance procedures must be developed to keep the property in good condition.
- e) When Nonexpendable Property/Equipment and/or Capital Assets are no longer in operational use by the Subrecipient, an updated Property Control Form must be submitted to AZDOHS immediately. The disposition of equipment shall be in compliance with the AZDOHS Disposition Guidance and 2 CFR 200. If the Subrecipient is requesting disposition of Capital Assets for reasons other than theft, destruction, or loss, the Subrecipient must submit an Equipment Disposition Request Form and receive approval prior to the disposition. The Equipment Disposition Request Form can be found at www.azdohs.gov.
- f) Equipment Record Retention
 - a. 2 CFR 200.333 (c): Records for real property and equipment acquired with Federal funds must be retained for three (3) years after final disposition.

Allowable Costs

The allowability of costs incurred under this agreement shall be determined in accordance with the general principles of allowability and standards for selected cost items as set forth in the applicable Code of Federal Regulations, authorized equipment lists, and guidance documents referenced above.

- a) The Subrecipient agrees that grant funds for any indirect costs that may be incurred are in accordance with 2 CFR 200 and the applicable NOFO. Indirect costs must be applied for and approved in writing by the AZDOHS prior to expenditure and reimbursement.

- b) The Subrecipient agrees that grant funds are not to be expended for any Management and Administrative (M&A) costs that may be incurred by the Subrecipient for administering these funds unless explicitly applied for and approved in writing by the AZDOHS and shall be in compliance with the applicable NOFO.

VIII. DEBARMENT CERTIFICATION

The Subrecipient agrees to comply with the Federal Debarment and Suspension regulations as outlined in the “Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions.” All recipients must comply with Executive Orders 12549 and 12689, and 2 CFR 200.213 which provide protection against waste, fraud, and abuse by debarment or suspending those persons deemed irresponsible in their dealings with the Federal government.

IX. FUNDS MANAGEMENT

The Subrecipient must maintain funds received under this Agreement in separate ledger accounts and cannot mix these funds with funds from other sources. The Subrecipient must manage funds according to applicable Federal regulations for administrative requirements, costs principles, and audits.

The Subrecipient must maintain adequate business systems to comply with Federal requirements. The business systems that must be maintained are:

- Financial Management
- Procurement
- Personnel
- Property
- Travel

A system is adequate if it is 1) written; 2) consistently followed – it applies in all similar circumstances; and 3) consistently applied – it applies to all sources of funds.

X. REPORTING REQUIREMENTS

Regular reports by the Subrecipient shall include:

a) Programmatic Reports

The Subrecipient shall provide quarterly programmatic reports to the AZDOHS within fifteen (15) calendar days of the last day of the quarter in which services are provided. The Subrecipient shall use the form provided by the AZDOHS to submit quarterly programmatic reports. The report shall contain such information as deemed necessary by the AZDOHS. The Subrecipient shall use the Quarterly Programmatic Report form, which is posted at www.azdohs.gov. Quarterly programmatic reports shall be submitted to the AZDOHS until the entire scope of the project is completed. If the scope of the project has been fully completed and implemented, and there will be no further updates, then the quarterly programmatic report for the quarter in which the project was completed will be sufficient as the final report. The report should be marked as final and should be inclusive of all necessary and pertinent information regarding the project as deemed necessary by the AZDOHS.

- b) Subrecipients must provide substantial/detailed information as to the status of completion of the milestones included in the application. Failure to adequately provide complete information will result in the Quarterly Report being rejected and resubmission will be required.

c) Quarterly Programmatic Reports are due:

January 15 (for the period from October 1– December 31)

April 15 (for the period from January 1 – March 31)

July 15 (for the period from April 1 – June 30)

October 15 (for the period from July 1 – September 30)

d) Final Quarterly Report:

The final quarterly report is due no more than fifteen (15) calendar days after the end of the performance period. Subrecipient may submit a final quarterly report prior to the end of the performance period if the scope of the project has been fully completed and implemented. The Property Control Form is due with the final quarterly report (if applicable).

e) Property Control Form – if applicable:

The Subrecipient shall provide the AZDOHS a copy of the Property Control Form with the final quarterly report.

a. In case of equipment disposition:

The Property Control Form shall be updated and a copy provided to AZDOHS no more than forty-five (45) calendar days after equipment disposition, if applicable. The disposition of equipment must be in compliance with the AZDOHS Disposition Guidance and 2 CFR 200.313.

f) Financial Reimbursements

The Subrecipient shall provide AZDOHS with requests for reimbursement as frequently as monthly but not less than quarterly. Reimbursement requests are only required when expenses have been incurred. Reimbursement requests shall be submitted with the Reimbursement Form provided by the AZDOHS staff. The Subrecipient shall submit a final reimbursement request for expenses received and invoiced prior to the end of the period of performance. The final reimbursement must be received by AZDOHS no more than **forty-five (45) calendar days** after the end of the period of performance. Requests for reimbursement received by AZDOHS later than **forty-five (45) calendar days** after the end of the period of performance will not be paid. The final reimbursement request as submitted shall be marked as final.

Subrecipients will only be reimbursed for expenses that have been obligated, expended and received within the authorized Period of Performance as identified in Section II of this Agreement. Subrecipients are not authorized to obligate or expend funds prior to the start date of the Period of Performance. Any expenses obligated or expended prior to the Period of Performance start date will be deemed unallowable and will not be reimbursed. Any expenses/services that occur beyond the Period of Performance (i.e. cell phone service) will be deemed unallowable and will not be reimbursed.

The AZDOHS requires that all requests for reimbursement are submitted via United States Postal Service, FedEx, UPS, etc. or in person. Reimbursement requests submitted via fax or by any electronic means will not be accepted.

The AZDOHS reserves the right to request and/or require any supporting documentation and/or information it feels necessary in order to process reimbursements. Subrecipient shall promptly provide AZDOHS with all such documents and/or information.

All reports shall be submitted to the contact person as described in Paragraph XXXVII, NOTICES, of this Agreement.

XI. ASSIGNMENT AND DELEGATION

The Subrecipient may not assign any rights hereunder without the express, prior written consent of both parties.

XII. AMENDMENTS

Any change in this Agreement including but not limited to the Description of Services and budget described herein, whether by modification or supplementation, must be accomplished by a formal Agreement amendment signed and approved by and between the duly authorized representative of the Subrecipient and the AZDOHS. In the event of any new legislation, laws, ordinances, or rules affecting this Agreement, the parties agree that the terms of this Agreement shall automatically incorporate the terms of such new legislation, laws, ordinances, or rules.

Any such amendment shall specify: 1) an effective date; 2) any increases or decreases in the amount of the Subrecipient's compensation, if applicable; 3) be titled as an "Amendment," and 4) be signed by the parties identified in the preceding paragraph. The Subrecipient expressly and explicitly understands and agrees that no other method of communication, including any other document, correspondence, act, or oral communication by or from any person, shall be used or construed as an amendment or modification or supplementation to this Agreement.

XIII. US DEPARTMENT OF HOMELAND SECURITY AGREEMENT ARTICLES

Article A - Disposition of Equipment Acquired Under the Federal Award

When original or replacement equipment acquired in conjunction with this Agreement by the Subrecipient is no longer needed for the original project or program or for other activities currently or previously supported by DHS/FEMA, the Subrecipient must request instructions from DHS/FEMA via AZDOHS by submitting an Equipment Disposition Request Form in order to make proper disposition of the equipment pursuant to 2 CFR section 200.313.

Article B – Acceptance of Post Award Changes

In the event FEMA determines that changes are necessary to this Agreement after it has been entered into, including changes to period of performance or terms and conditions, the Subrecipient will be notified of the changes in writing. Once notification has been made, any subsequent request for funds by Subrecipient will constitute Subrecipient's acceptance of the changes to this Agreement and the incorporation of such changes into this Agreement.

Article C - Procurement of Recovered Materials

The Subrecipient hereby acknowledges and agrees that it must comply with section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act, and that the requirements of Section 6002 include procuring only items designated in guidelines of the Environmental Protection Agency (EPA) at 40 CFR Part 247 that contain the highest percentage of recovered materials practicable, consistent with maintaining a satisfactory level of competition.

Article D - Whistleblower Protection Act

The Subrecipient hereby acknowledges and agrees that it must comply with the statutory requirements for whistleblower protections (if applicable) at 10 U.S.C section 2409, 41 U.S.C. 4712, and 10 U.S.C. section 2324, 41 U.S.C. section 4304 and 4310.

Article E - Use of DHS Seal, Logo and Flags

Subrecipient hereby acknowledges that it must obtain DHS's approval prior to using the DHS seal(s), logos, crests or reproductions of flags or likenesses of DHS agency officials, including use of the United States Coast Guard seal, logo, crests or reproductions of flags or likenesses of Coast Guard officials.

Article F - USA Patriot Act of 2001

Subrecipient hereby acknowledges and agrees that it must comply with the requirements of the Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act (USA PATRIOT Act), which amends 18 U.S.C. section 175–175c.

Article G – Universal Identifier and System of Award Management (SAM)

Subrecipient hereby acknowledges and agrees that it must comply with the requirements set forth in the government-wide financial assistance award term regarding the System for Award Management and Universal Identifier Requirements located at 2 C.F.R. Part 25, Appendix A.

Article H - Reporting of Matters Related to Recipient Integrity and Performance

If the total value of your currently active grants, cooperative agreements, and procurement contracts from all Federal assistance offices exceeds \$10,000,000 for any period of time during the period of performance of this Federal award, you must comply with the requirements set forth in the government-wide Award Term and Condition for Recipient Integrity and, Performance Matters located at 2 C.F.R. Part 200 Appendix XII, the full text of which is incorporated here by reference in the terms and conditions of your award.

Article I - Rehabilitation Act of 1973

The Subrecipient hereby acknowledges and agrees that it must comply with the requirements of Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. section 794, as amended, which provides that no otherwise qualified handicapped individual in the United States will, solely by reason of the handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. These requirements pertain to the provision of benefits or services as well as to employment.

Article J - Trafficking Victims Protection Act of 2000

Subrecipient hereby acknowledges and agrees that it must comply with the requirements of the government-wide award term which implements Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. section 7104). The award term is located at 2 C.F.R. Part 175, the full text of which is incorporated here by reference.

Article K - Terrorist Financing

The Subrecipient hereby acknowledges and agrees that it must comply with U.S. Executive Order 13224 and U.S. law that prohibit transactions with, and the provisions of resources and support to, individuals and organizations associated with terrorism. It is the legal responsibility of the Subrecipient to ensure compliance with the Order and laws.

Article L - SAFECOM

The Subrecipient hereby acknowledges and agrees that recipients who receive awards made under programs that provide emergency communication equipment and its related activities must comply with the SAFECOM Guidance for Emergency Communication Grants, including provisions on technical standards that ensure and enhance interoperable communications.

Article M - Reporting Subawards and Executive Compensation

All Subrecipients are required to comply with the requirements set forth in the government-wide Award Term on Reporting Subawards and Executive Compensation located at 2 CFR Part 170, Appendix A, the full text of which is incorporated here by reference in the terms and conditions of your award.

Article N – Department and Suspension

The Subrecipient hereby acknowledges and agrees that it is subject to the non-procurement debarment and suspension regulations implementing Executive Orders (E.O.) 12549 and 12689, and 2 C.F.R. Part 180. These regulations restrict Federal financial assistance awards, subawards, and contracts with certain parties that are debarred, suspended, or otherwise excluded from or ineligible for participation in Federal assistance programs or activities.

Article O - Copyright

The Subrecipient hereby acknowledges and agrees that it must affix the applicable copyright notices of 17 U.S.C. sections 401 or 402 and an acknowledgement of Government sponsorship (including award number) to any work first produced under Federal financial assistance awards.

Article P - Civil Rights Act of 1964 - Title VI

The Subrecipient hereby acknowledges and agrees that it must comply with the requirements of Title VI of the Civil Rights Act of 1964 (42 U.S.C. section 2000d et seq.), codified at 6 C.F.R. Part 21 and 44 C.F.R. Part 7, which provides that no person in the United States will, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

Article Q - Best Practices for Collection and Use of Personally Identifiable Information (PII)

The Subrecipient hereby acknowledges and agrees that if they collect PII they are required to have a publically-available privacy policy that describes standards on the usage and maintenance of PII they collect. DHS defines personally identifiable information (PII) as any information that permits the identity of an individual to be directly or indirectly inferred, including any information that is linked or linkable to that individual. Recipients may also find the DHS Privacy Impact Assessments: Privacy Guidance and Privacy template as useful resources respectively.

Article R - Americans with Disabilities Act of 1990

The Subrecipient hereby acknowledges and agrees that it shall comply with all State and Federal equal opportunity and non-discrimination requirements and conditions of employment, including but not limited to Arizona Executive Order 2009-9 and the requirements of Titles I, II, and III of the Americans with Disabilities Act, which prohibits recipients from discriminating on the basis of disability in the operation of public entities, public and private transportation systems, places of public accommodation, and certain testing entities (42 U.S.C. sections 12101–12213).

Article S - Age Discrimination Act of 1975

The Subrecipient hereby acknowledges and agrees that it must comply with the requirements of the Age Discrimination Act of 1975 (42 U.S.C. section 6101 et seq.), which prohibits discrimination on the basis of age in any program or activity receiving Federal financial assistance.

Article T - Activities Conducted Abroad

The Subrecipient hereby acknowledges and agrees that it must ensure that project activities carried on outside the United States are coordinated as necessary with appropriate government authorities and that appropriate licenses, permits, or approvals are obtained.

Article U - Acknowledgement of Federal Funding from DHS

The Subrecipient hereby acknowledges and agrees that it must acknowledge its use of federal funding when issuing statements, press releases, requests for proposals, bid invitations, and other documents describing projects or programs funded in whole or in part with Federal funds.

Article V - DHS Specific Acknowledgements and Assurances

Subrecipient hereby acknowledges and agrees—and agrees to require any contractors, successors, transferees, and assignees acknowledge and agree—to comply with applicable provisions governing DHS access to records, accounts, documents, information, facilities, and staff.

1. Subrecipient hereby agrees to cooperate with any compliance review or complaint investigation conducted by DHS.

2. Subrecipient hereby agrees to give DHS access to and the right to examine and copy records, accounts, and other documents and sources of information related to the grant and permit access to facilities, personnel, and other individuals and information as may be necessary, as required by DHS regulations and other applicable laws or program guidance.
3. Subrecipient hereby agrees to submit timely, complete, and accurate reports to the appropriate DHS officials and maintain appropriate backup documentation to support the reports.
4. Subrecipient hereby agrees to comply with all other special reporting, data collection, and evaluation requirements, as prescribed by law or detailed in program guidance.
5. If, during the past three years, the Subrecipient has been accused of discrimination on the grounds of race, color, national origin (including limited English proficiency), sex, age, disability, religion, or familial status, the Subrecipient shall provide a list of all such proceedings, pending or completed, including outcome and copies of settlement agreements to the DHS financial assistance office and the DHS Office of Civil Rights and Civil Liberties (CRCL) by email at crcl@hq.dhs.gov or by mail at U.S. Department of Homeland Security Office of Civil Rights and Civil Liberties Building 410, Mail Stop #0190 Washington, D.C. 20528.
6. In the event any court or administrative agency makes a finding of discrimination by Subrecipient (or any of its contractors or subcontractors involved in providing goods or services under this Agreement) on grounds of race, color, national origin (including limited English proficiency), sex, age, disability, religion, or familial status against the recipient, or the recipient settles a case or matter alleging such discrimination, Subrecipient must forward a copy of the complaint and findings to the DHS financial assistance office and the CRCL office by email or mail at the addresses listed above.

Subrecipient hereby acknowledges and agrees that the United States has the right to seek judicial enforcement of these obligations.

Article W - Assurances, Administrative Requirements and Cost Principles, and Audit Requirements

The Subrecipient hereby acknowledges and agrees that it must complete OMB Standard Form 424B Assurances – Non-Construction Programs, or OMB Standard Form 424D Assurances – Construction Programs as applicable. Certain assurances in this document may not be applicable to this Agreement, and the awarding agency may require applicants to certify additional assurances. Please contact the program awarding office if you have any questions.

DHS financial assistance recipients are required to follow the applicable provisions of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards located at Title 2, Code of Federal Regulations, Part 200, and adopted by DHS at 2 C.F.R. Part 3002.

Article X - Patents and Intellectual Property Rights

Unless otherwise provided by law, the Subrecipient hereby acknowledges and agrees that it is subject to the Bayh-Dole Act, Pub. L. No. 96-517, as amended, and codified in 35 U.S.C. section 200 et seq., and that it is subject to the specific requirements governing the development, reporting, and disposition of rights to inventions and patents resulting from financial assistance awards are in 37 CFR Part 401 and the standard patent rights clause in 37 CFR section 401.14.

Article Y – Notice of Funding Opportunity Requirements

All of the instructions, guidance, limitations, and other conditions set forth in the Notice of Funding Opportunity (NOFO) for this program are incorporated here by reference in the award terms and conditions. The Subrecipient hereby acknowledges and agrees that it must comply with any such requirements set forth in the program NOFO.

Article Z – Non-supplanting Requirement

The Subrecipient receiving Federal financial assistance awards made under programs that prohibit supplanting by law must ensure that Federal funds do not replace (supplant) funds that have been budgeted for the same purpose through non-Federal sources.

Article AA – Nondiscrimination in Matters Pertaining to Faith-Based Organizations

It is DHS policy to ensure the equal treatment of faith-based organizations in social service programs administered or supported by DHS or its component agencies, enabling those organizations to participate in providing important social services to beneficiaries. All Subrecipients must comply with the equal treatment policies and requirements contained in 6 CFR Part 19 and other applicable statutes, regulations, and guidance governing the participations of faith-based organizations in individual DHS programs.

Article AB – National Environmental Policy Act

All Subrecipients must comply with the requirements of the National Environmental Policy Act (NEPA) 42 U.S.C. 4321 et seq., and the Council on Environmental Quality (CEQ) Regulations (40 C.F.R. 1500-1508) for Implementing the Procedural Provisions of NEPA, which requires Subrecipients to use all practicable means within their authority, and consistent with other essential considerations of national policy, to create and maintain conditions under which people and nature can exist in productive harmony and fulfill the social, economic, and other needs of present and future generations of Americans.

Article AC - Lobbying Prohibitions

The Subrecipient hereby acknowledges and agrees that it must comply with 31 U.S.C. section 1352, and acknowledges and agrees that none of the funds provided under this Agreement may be used to pay any person to influence, or attempt to influence an officer or employee of any agency (whether State or Federal), a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any Federal action related to a Federal award or contract, including any extension, continuation, renewal, amendment, or modification.

Article AD - Limited English Proficiency (Civil Rights Act of 1964, Title VI)

The Subrecipient hereby acknowledges and agrees that it must comply with the Title VI of the Civil Rights Act of 1964 (Title VI) prohibition against discrimination on the basis of national origin, which requires that recipients of federal financial assistance take reasonable steps to provide meaningful access to persons with Limited English Proficiency (LEP) to their programs and services. For additional assistance and information regarding language access obligations, please refer to the DHS Recipient Guidance <https://www.dhs.gov/guidance-published-help-department-supported-organizations-provide-meaningful-access-people-limited> and additional resources on <http://www.lep.gov>.

Article AE - Hotel and Motel Fire Safety Act of 1990

In accordance with Section 6 of the Hotel and Motel Fire Safety Act of 1990, 15 U.S.C. section 2225(a), the Subrecipient hereby acknowledges and agrees that it must ensure that all conference, meeting, convention, or training space funded in whole or in part with Federal funds complies with the fire prevention and control guidelines of the Federal Fire Prevention and Control Act of 1974, 15 U.S.C. section 2225.

Article AF - Fly America Act of 1974

The Subrecipient hereby acknowledges and agrees that it must comply with the following Preference for U.S. Flag Air Carriers: Travel supported by U.S. Government funds requirement, which states preference for the use of U.S. flag air carriers (air carriers holding certificates under 49 U.S.C. section 41102) for international air transportation of people and property to the extent that such service is available, in accordance with the International Air Transportation Fair Competitive Practices Act of 1974 (49 U.S.C. section 40118) and the interpretative guidelines issued by the Comptroller General of the United States in the March 31, 1981, amendment to Comptroller General Decision B138942.

Article AG - Federal Leadership on Reducing Text Messaging while Driving

All Subrecipients are encouraged to adopt and enforce policies that ban text messaging while driving as described in Executive Order 13513, including conducting initiatives described in Section 3(a) of the Order when on official Government business or when performing any work for or on behalf of the federal government.

Article AH - Federal Debt Status

The Subrecipient hereby acknowledges and agrees that it is required to be non-delinquent in their repayment of any Federal debt. Examples of relevant debt include delinquent payroll and other taxes, audit disallowances, and benefit overpayments. See OMB Circular A-129.

Article AI - False Claims Act and Program Fraud Civil Remedies

The Subrecipient hereby acknowledges and agrees that it must comply with the requirements of The False Claims Act (31 U.S.C. Section 3729) which prohibits the submission of false or fraudulent claims for payment to the Federal government. See also 38 U.S.C. sections 3801-3812 which details the administrative remedies for false claims and statements made.

Article AJ - Energy Policy and Conservation Act

The Subrecipient hereby acknowledges and agrees that it must comply with the requirements of The Energy Policy and Conservation Act (42 U.S.C. Chapter 77) which contain policies relating to energy efficiency that are defined in the state energy conservation plan issued in compliance with this Act.

Article AK - Education Amendments of 1972 (Equal Opportunity in Education Act) – Title IX

The Subrecipient hereby acknowledges and agrees that it must comply with the requirements of Title IX of the Education Amendments of 1972 (20 U.S.C. section 1681 et seq.), which provides that no person in the United States will, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any educational program or activity receiving Federal financial assistance. These regulations are codified at 6 CFR Part 17 and 44 CFR Part 19.

Article AL - Duplication of Benefits

Any cost allocable to a particular Federal award, provided for in 2 CFR Part 200, Subpart E may not be charged to other Federal awards to overcome fund deficiencies, to avoid restrictions imposed by Federal statutes, regulations, or terms and conditions of the Federal awards, or for other reasons. However, this prohibition would not preclude a Subrecipient from shifting costs that are allowable under two or more Federal awards in accordance with existing Federal statutes, regulations, or the terms and conditions of the Federal award.

Article AM - Drug-Free Workplace Regulations

The Subrecipient hereby acknowledges and agrees that it must comply drug-free workplace requirements in Subpart B (or Subpart C, if the Subrecipient is an individual) of 2 C.F.R. part 30001, which adopts the Government-wide implementation (2 C.F.R. part 182) of sec. 5152-5158 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 8101).

Article AN - Civil Rights Act of 1968

The Subrecipient hereby acknowledges and agrees that it must comply with Title VIII of the Civil Rights Act of 1968, which prohibits recipients from discriminating in the sale, rental, financing, and advertising of dwellings, or in the provision of services in connection therewith, on the basis of race, color, national origin, religion, disability, familial status, and sex (42 U.S.C. section 3601 et seq.), as implemented by the Department of Housing and Urban Development at 24 CFR Part 100. The prohibition on disability discrimination includes the requirement that new multifamily housing with four or more dwelling units—i.e., the public and common use areas and individual apartment units (all units in buildings with elevators and ground-floor units in buildings without elevators)—be designed and constructed with certain accessible features (see 24 CFR section 100.201).

XIV. OFFSHORE PERFORMANCE OF WORK PROHIBITED

Due to security and identity protection concerns, all services under this Agreement shall be performed within the borders of the United States. All storage and processing of information shall be performed within the borders of the United States. This provision applies to work performed by the Subrecipient's contractors and subcontractors at all tiers.

XV. AGREEMENT RENEWAL

This Agreement shall not bind nor purport to bind the AZDOHS for any contractual commitment in excess of the original Agreement period.

XVI. RIGHT TO ASSURANCE

If the AZDOHS in good faith has reason to believe that the Subrecipient does not intend to, or is unable to perform or continue performing under this Agreement, the AZDOHS may demand in writing that the Subrecipient give a written assurance of intent to perform. If the Subrecipient fails to provide written assurance within the number of days specified in the demand, the AZDOHS at its option may terminate this Agreement.

XVII. CANCELLATION FOR CONFLICT OF INTEREST

The AZDOHS may, by written notice to the Subrecipient, immediately cancel this Agreement without penalty or further obligation pursuant to A.R.S. section 38-511 if any person significantly involved in initiating, negotiating, securing, drafting, or creating the Agreement on behalf of the State or its subdivisions (unit of Local Government) is an employee or agent of any other party in any capacity or a consultant to any other party to the Agreement with respect to the subject matter of the Agreement. Such cancellation shall be effective when the parties to the Agreement receive written notice from the AZDOHS, unless the notice specifies a later time.

XVIII. THIRD PARTY ANTITRUST VIOLATIONS

The Subrecipient hereby assigns to the State of Arizona any claim for overcharges resulting from antitrust violations to the extent that such violations concern materials or services supplied by third parties to Subrecipient toward fulfillment of this Agreement.

XIX. AVAILABILITY OF FUNDS

Every payment obligation of the AZDOHS under this Agreement is conditioned upon the availability of funds appropriated or allocated for the payment of such obligations under A.R.S. section 35-154. If the funds are not allocated and available for the continuance of this Agreement, the AZDOHS may terminate this Agreement at the end of the period for which funds are available. No liability shall accrue to the AZDOHS in the event this provision is exercised, and the AZDOHS shall not be obligated or liable for any future payments or for any damages as a result of termination under this paragraph, including purchases and/or contracts entered into by the Subrecipient in the execution of this Agreement.

XX. FORCE MAJEURE

If either party hereto is delayed or prevented from the performance of any act required in this Agreement by reason of acts of God, strikes, lockouts, labor disputes, civil disorder, or other causes without fault and beyond the control of the party obligated, performance of such act will be excused for the period of the delay.

XXI. PARTIAL INVALIDITY

Any term or provision of this Agreement that is hereafter declared contrary to any current or future law, order, regulation, or rule, or which is otherwise invalid, shall be deemed stricken from this Agreement without impairing the validity of the remainder of this Agreement.

XXII. ARBITRATION

In the event of any dispute arising under this Agreement, written notice of the dispute must be provided to the other party within thirty (30) calendar days of the events giving the rise to the dispute. Any claim made by or against the State or any of its political subdivisions (including but not limited to AZDOHS) relating to this Agreement shall be resolved through the administrative claims process. In the event that the parties would otherwise be in court and/or if A.R.S. section 12-1518 applies, the parties shall proceed in arbitration through the American Arbitration Association ("AAA"), with the arbitrator to be selected pursuant to AAA rules and the arbitration to be conducted according to the applicable AAA rules, and with the costs of arbitration (including but not limited to the arbitrator's fees and costs) to be divided 50/50 between the parties, subject to reallocation between the parties by the arbitrator. In the event that the parties become involved in litigation with each other relating to this Agreement for any reason in any other forum, both parties agree to have any claim(s) resolved in arbitration on the terms set forth in this part XXII. Any arbitration award may be enforced through the Maricopa County Superior Court or the U.S. District Court located in Phoenix, Arizona.

XXIII. GOVERNING LAW AND CONTRACT INTERPRETATION

- a) This Agreement shall be governed and interpreted in accordance with the laws of the State of Arizona.
- b) This Agreement is intended by the parties as a final and complete expression of their agreement. No course of prior dealings between the parties and no usage of the trade shall supplement or explain any terms in this document.
- c) Either party's failure to insist on strict performance of any term or condition of the Agreement shall not be deemed a waiver of that term or condition even if the party accepting or acquiescing in the nonconforming performance knows of the nature of the performance and fails to object.

XXIV. ENTIRE AGREEMENT

This Agreement constitutes the entire Agreement between the parties hereto pertaining to the subject matter hereof and may not be changed or added to except by a writing signed by all parties hereto in conformity with Paragraph XII, AMENDMENTS. The Subrecipient agrees to comply with any such amendment within ten (10) business days of receipt of a fully executed amendment. All prior and contemporaneous agreements, representations, and understandings of the parties, oral, written, pertaining to the subject matter hereof, are hereby superseded or merged herein.

XXV. LICENSING

The Subrecipient, unless otherwise exempted by law, shall obtain and maintain all licenses, permits, and authority necessary to perform those acts it is obligated to perform under this Agreement.

XXVI. SECTARIAN REQUESTS

Funds disbursed pursuant to this Agreement may not be expended for any sectarian purpose or activity, including sectarian worship or instruction in violation of the United States or Arizona Constitutions.

XXVII. ADVERTISING AND PROMOTION OF AGREEMENT

The Subrecipient shall not advertise or publish information for commercial benefit concerning this Agreement without the written approval of the AZDOHS.

XXVIII. OWNERSHIP OF INFORMATION, PRINTED AND PUBLISHED MATERIAL

The AZDOHS reserves the right to review and approve any publications funded or partially funded through this Agreement. All publications funded or partially funded through this Agreement shall recognize the AZDOHS and the U.S. Department of Homeland Security. The U.S. Department of Homeland Security and the AZDOHS shall have full and complete rights to reproduce, duplicate, disclose, perform, and otherwise use all materials prepared under this Agreement.

The Subrecipient agrees that any report, printed matter, or publication (written, visual, or sound, but excluding press releases, newsletters, and issue analyses) issued by the Subrecipient describing programs or projects funded in whole or in part with Federal funds shall contain the following statement:

"This document was prepared under a grant from the U.S. Department of Homeland Security. Points of view or opinions expressed in this document are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Homeland Security."

The Subrecipient also agrees that one copy of any such publication, report, printed matter, or publication shall be submitted to the AZDOHS to be placed on file and distributed as appropriate to other potential subrecipients or interested parties. The AZDOHS may waive the requirement for submission of any specific publication upon submission of a request providing justification from the Subrecipient.

The AZDOHS and the Subrecipient recognize that research resulting from this Agreement has the potential to become public information. However, prior to the termination of this Agreement, the Subrecipient agrees that no research-based data resulting from this Agreement shall be published or otherwise distributed in any form without express written permission from the AZDOHS and possibly the U.S. Department of Homeland Security. It is also agreed that any report or printed matter completed as a part of this agreement is a work for hire and shall not be copyrighted by the Subrecipient.

XXIX. CLOSED-CAPTIONING OF PUBLIC SERVICE ANNOUNCEMENTS

Any television public service announcement that is produced or funded in whole or in part by the Subrecipient shall include closed captioning of the verbal content of such announcement.

XXX. INDEMNIFICATION

Each party (as "Indemnitor") agrees to defend, indemnify, and hold harmless the other party (as "Indemnitee") from and against any and all claims, losses, liability, costs, or expenses (including reasonable attorney's fees) (hereinafter collectively referred to as "Claims") arising out of bodily injury of any person (including death) or property damage, but only to the extent that such Claims which result in vicarious/derivative liability to the Indemnitee are caused by the act, omission, negligence, misconduct, or other fault of the Indemnitor, its officers, officials, agents, employees, or volunteers. The State of Arizona, (AZDOHS) is self-insured per A.R.S. 41-621.

In addition, should Subrecipient utilize a contractor(s) and subcontractor(s), the indemnification clause between Subrecipient and contractor(s) and subcontractor(s) shall include the following:

Contractor shall defend, indemnify, and hold harmless the (insert name of other governmental entity) and the State of Arizona, and any jurisdiction or agency issuing any permits for any work arising out of this Agreement, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees (hereinafter referred to as "Indemnitee") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including court costs, attorneys' fees, and costs of claim processing, investigation and litigation) (hereinafter referred to as "Claims") for bodily injury or personal injury (including death), or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of the contractor or any of the directors, officers, agents, or employees or subcontractors of such contractor. This indemnity includes any claim or amount arising out of or recovered under the Workers' Compensation Law or arising out of the failure of such contractor to conform to any federal, state or local law, statute, ordinance, rule, regulation or court decree. It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by such contractor from and against any and all claims. It is agreed that such contractor will be responsible for primary loss investigation, defense and judgment costs where this indemnification is applicable. Additionally on all applicable insurance policies, contractor and its subcontractors shall name the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees as an additional insured and also include a waiver of subrogation in favor of the State.

XXXI. TERMINATION

- a) All parties reserve the right to terminate the Agreement in whole or in part due to the failure of the Subrecipient or AZDOHS to comply with any term or condition of the Agreement, to acquire and maintain all required insurance policies, bonds, licenses, and permits or to make satisfactory progress in performing the Agreement. The staff of either party shall provide a written thirty (30) day advance notice of the termination and the reasons for it.
- b) If the Subrecipient chooses to terminate the Agreement before the grant deliverables have been met then the AZDOHS reserves the right to collect all reimbursements distributed to the Subrecipient.
- c) The AZDOHS may, upon termination of this Agreement, procure, on terms and in the manner that it deems appropriate, materials or services to replace those under this Agreement. The Subrecipient shall be liable to the AZDOHS for any excess costs incurred by the AZDOHS in procuring materials or services in substitution for those due from the Subrecipient.

XXXII. CONTINUATION OF PERFORMANCE THROUGH TERMINATION

The Subrecipient shall continue to perform, in accordance with the requirements of the Agreement, up to the date of termination, as directed in the termination notice.

XXXIII. PARAGRAPH HEADINGS

The paragraph headings in this Agreement are for convenience of reference only and do not define, limit, enlarge, or otherwise affect the scope, construction, or interpretation of this Agreement or any of its provisions.

XXXIV. COUNTERPARTS

This Agreement may be executed in any number of counterparts, copies, or duplicate originals. Each such counterpart, copy, or duplicate original shall be deemed an original, and collectively they shall constitute one agreement.

XXXV. AUTHORITY TO EXECUTE THIS AGREEMENT

Each individual executing this Agreement on behalf of the Subrecipient represents and warrants that he or she is duly authorized to execute this Agreement.

XXXVI. SPECIAL CONDITIONS

- a) The Subrecipient must comply with the most recent version of the Administrative Requirements, Cost Principles, and Audit requirements.
- b) The Subrecipient acknowledges that the DHS and the AZDOHS reserve a royalty-free, non-exclusive, and irrevocable license to reproduce, publish, or otherwise use, and authorize others to use, for Federal government purposes: (a) the copyright in any work developed under an award or sub-award; and (2) any rights of copyright to which a subrecipient purchases ownership with Federal support. The Subrecipient shall consult with the AZDOHS regarding the allocation of any patent rights that arise from, or are purchased with, this funding.
- c) The Subrecipient agrees to cooperate with any assessments, state/national evaluation efforts, or information or data collection requests, including, but not limited to, the provision of any information required for the assessment or evaluation of any activities within this agreement.
- d) The Subrecipient is prohibited from transferring funds between programs (e.g., State Homeland Security Program, Urban Area Security Initiative, Operation Stonegarden).

NOTICES

Any and all notices, requests, demands, or communications by either party to this Agreement, pursuant to or in connection with this Agreement shall be in writing, be delivered in person, or shall be sent to the respective parties at the following addresses:

Arizona Department of Homeland Security
1700 West Washington Street, Suite 210
Phoenix, AZ 85007

The Subrecipient shall address all programmatic and reimbursement notices relative to this Agreement to the appropriate AZDOHS staff; contact information at www.azdohs.gov.

The AZDOHS shall address all notices relative to this Agreement to:

Enter Title, First & Last Name Above

Enter Street Address Above

Enter City, State, ZIP Above

XXXVIII. IN WITNESS WHEREOF

The parties hereto agree to execute this Agreement.

FOR AND BEHALF OF THE

Authorized Signature Above

Print Name & Title Above

Enter Date Above

FOR AND BEHALF OF THE

Arizona Department of Homeland Security

Gilbert M. Orrantia
Director

Date

(Complete and mail two original documents to the Arizona Department of Homeland Security.)

Name/Address

San Luis Police Department
Lt. Miguel Alvarez
1030 E. Union Street
San Luis, Arizona 85349

Date	Estimate No.	Project
03/27/19	1252	

Item	Description	Quantity	Cost	Total
CF-33LE-06VM	PANASONIC : Public Sector Specific,Win10 Pro,Core i5-7300U,12in Touch+Digitizer,8GB,256GB SSD,Intel a/b/g/n/ac,TPM 2.0,BT,Dual Pass (Upper:WWAN/Lower:dGPS),4G LTE Multi Carrier (EM7455),dGPS,Webcam,8MP Cam,Contactless SmartCard,2D Bar Laser(N6603),Toughbook Preferred	17	2,550.00	43,350.00T
CF-VVK331M	PANASONIC : 33 Vehicle Dock Adapter (VDA) Bundle-dual pass.For CF-33.Includes Lite Keyboard.USB 2.0, Dual RF, Docking Connector, Key Lock, Tablet Release with Lock/Unlock, Keyboard Release.VDA fits in any Gamber-Johnson/Havis 31 Vehicle Dock.Coil cable not included.	19	465.00	8,835.00T
CF-VST332U	PANASONIC : Rotating Hand Strap for CF-33.Not compatible with 33 Vehicle Tablet Dock when using CF-33 with both Long Life Battery and Rotating Hand Strap.Includes stylus pen holder and kickstand.	17	70.50	1,198.50T
7110-1214	PANASONIC-Gamber Johnson stiffner for use with GJ laptop 2 in 1 vehicle docks for CF-33.	17	35.00	595.00T
	AZ State Sales Tax		9.30%	5,020.00
NASPO Contract # ADSP018-183112 NASPO			Total	\$58,998.50



AGENDA ITEM REVIEW FORM

Special City Council Meeting

4.D.

Meeting Date: 06/25/2019

Department Head: Jose A. Guzman, Director of Planning & Zoning, Planning & Zoning Department

Submitted By: Jose A. Guzman, Director of Planning & Zoning, Planning & Zoning Department

Action Requested: Motion

ITEM:

Discussion and possible action on any and all matters regarding Memorandum of Understanding between the City of San Luis and Comite de Bienestar Inc. for the proposed Lot Split Case No. 2019-0113. **(Jose A. Guzman, Director of Planning and Zoning)**

SUMMARY:

A Memorandum of Understanding between the City of San Luis, Arizona and Comite de Bienestar Inc. AZ Corp, pertaining to Lot Split Case No. 2019-0013.

A request by Vega & Vega Engineering, PLC, on behalf of Comite de Bienestar Inc., owner, for the review and approval of Bienestar Estates 10 lot split located on the southeast corner of Avenue F and County 24th Street. Assessor's Parcel Number 227-15-01 is proposed to be divided in two, creating Parcel "A" and Parcel "B". The property is currently zoned Community Commercial Zoning District (C-2) and Medium Density Residential (R1-6).

The purpose of the lot split is to allow construction of Bienestar Estates 10 Subdivision to be located in the proposed parcel A. Section 7.1 of the Subdivision Regulations of the City provide in part that lot splits may be approved if the division of land is into three or fewer parcels and does not involve right-of-way dedication, utility extension, or other off-site public improvements. The proposed lot split involves future right-of-way dedication, utility extension and off-site improvements, therefore is not allowed to be processed as a lot split under the Subdivision Regulations. The purpose of the Memorandum of Understanding is to make appropriate provision for future right-of-way dedications, utility extensions, and off-site public improvements such that the application for Lot Split Case No. 2019-0113 can be approved.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE THE MEMORANDUM OF UNDERSTANDING AS PRESENTED.

N/A

Fiscal Impact

IS THERE FISCAL IMPACT ASSOCIATED WITH THIS ITEM:	N/A
CITY/STATE/FEDERAL FUNDS:	N/A
TOTAL:	N/A
BUDGETED AMOUNT:	N/A
AVAILABLE AMOUNT TO TRANSFER:	N/A

ACCT NAME & GL#/REMAINING BALANCE BEFORE PURCHASE: N/A
FISCAL IMPACT STATEMENT (IF THIS IS A BUDGET TRANSFER, YOU MUST ATTACH THE BUDGET ADJUSTMENT FORM):
N/A

Attachments

Memorandum of Understanding

When recorded mail to:

City Clerk
City of San Luis
P.O. Box 1170
San Luis, Arizona 85349

MEMORANDUM OF UNDERSTANDING

Comes now the City of San Luis, Arizona, a municipal corporation and political subdivision of the State of Arizona ("City") and Comite de Bienestar, Inc. ("Owner") and hereby make this agreement on the _____ day of _____, 2019 to an understanding regarding the proposed lot split for Bienestar Estates 10 ("City Lot Split Case Number 2019-0113") located on the southeast corner of Avenue F and County 24th street, in San Luis, Arizona.

WHEREAS, Owner is the owner of real property, Assessor's Parcel Number 227-15-001, and desires to split said parcel into three parcels pursuant to City Lot Split Case Number 2019-0113.

WHEREAS, a true and correct legal description of the property being divided, and to which this instrument applies, is marked "Exhibit A" attached hereto, and by this reference is incorporated herein as though fully set forth again in full.

WHEREAS, Section 7.1 of the Subdivision Regulations of the City provide in part that lot splits may be approved if the division of land is into three or fewer parcels and does not involve right-of-way dedication, utility extension, or other off-site public improvement.

WHEREAS, the Subdivision Regulations of the City do not allow for a lot split process under the particular circumstances of City Lot Split Case Number 2019-0113.

WHEREAS, the purpose of this Memorandum of Understanding is to make appropriate provision for right-of-way dedications, utility extensions, and off-site public improvements such that the application for City Lot Split Case Number 2019-0113 can be approved.

NOW, THEREFORE, intending to be legally bound hereby, the City and Owner agrees as follows:

1. At present time Owner shall dedicate appropriate right-of-way to the City along the County 24th Street alignments in accordance with the standards for right-of-way as provided by the City General Plan. Dedication of said right-of-way shall be by virtue of deed and said deed(s) shall be recorded before with any recordation of plat of lot split.
2. At such time that any lot created by City Lot Split Case Number 2019-0113 is developed, utility extensions and off-site public improvements will be made along the entirety of the lot in the discretion of the Public Works Director of City and shall conform to the Public Works Standards of the City. Development of such utility extensions and off-site public improvements shall be a

MEMORANDUM OF UNDERSTANDING

RE: Lot Split Case No. 2019-0113/Bienestar Estates 10

June 26, 2019

Page 2 of 4

condition of the issuance of any building permit(s) or other use permit(s) for the development of any such lot.

3. At such time that any lot created by City Lot Split Case Number 2019-0113 is developed the Public Works Director determines, in his sole discretion, that the development of street lights in the public right-of-way is needed or desired, development of such street lighting and the formation of a street lighting improvement district to maintain and pay for said lighting shall be a condition of the issuance of building permit(s) or other use permit(s) for the development of any such lot.
4. The undersigned represent to each other that they have full power and authority to enter into this Agreement, and that all necessary actions have been taken to give full force and effect to this Agreement. The Owner represents and warrants that it is duly formed and validly existing under the laws of the State of Arizona and that it is duly qualified to do business in the State of Arizona and is in good standing under applicable state laws. The Owner and the City warrant to each other that the individuals executing this Agreement on behalf of their respective parties are authorized and empowered to bind the party on whose behalf each individual is signing. The Owner represents to the City that by entering into this Agreement, the Owner has bound the Property and all persons and entities having any legal or equitable interest therein to the terms of this memorandum of understanding.
5. Any successor in interest to Owner shall be bound by the terms and conditions hereof.
6. Subject to the provisions hereof, upon compliance with the other terms and conditions of Section 7.1 of the Subdivisions Regulations and other appropriate ordinances and regulations of the City, City shall approve City Lot Split Case Number 2019-0113.
7. No delay in exercising any right or remedy shall constitute a waiver thereof, and no waiver by the parties of the breach of any provision of this Agreement shall be construed as a waiver of any preceding or succeeding breach of the same or of any other provision of this Agreement.
8. This Agreement, including the Exhibits hereto, which are incorporated herein by this reference, constitutes the entire agreement between the parties. This provision applies only to the entirety of this Agreement only; additional and separate zoning stipulations and agreements with the City may apply to the Property, and this provision has no effect on them.
9. This Agreement may be amended, in whole or in part and with respect to all or any portion of the Property, only with the mutual written consent of the parties to this Agreement or by their successor in interest or assigns. The City shall record the amendment or cancellation in the official records of the Yuma County Recorder.
10. If any other provision of the Agreement is declared void or unenforceable, such provision shall be severed from this Agreement, which shall otherwise remain in full force and effect.
11. The laws of the State of Arizona shall govern the interpretation and enforcement of this Agreement. The parties agree that venue for any action commenced in connection with this Agreement shall be proper only in a court of competent jurisdiction located in Yuma County, Arizona, and the parties hereby waive any right to object to such venue. This agreement is subject to the provisions of A.R.S. §38-511.

MEMORANDUM OF UNDERSTANDING

RE: Lot Split Case No. 2019-0113/Bienestar Estates 10

June 26, 2019

Page 3 of 4

12. This Agreement, and any amendment or cancellation of it shall be recorded in the official records of the Yuma County Recorder no later than ten (10) days after the City and the Owner execute such agreement amendment or cancellation.
13. If either party brings a legal action either because of a breach of this Agreement or to enforce a provision of this Agreement, the prevailing party will be entitled to reasonable attorney's fees and court costs.
14. There are no third-party beneficiaries to this Agreement, and no person or entity not a party hereto shall have any right or cause of action hereunder.
15. Nothing contained in this Agreement shall create any partnership, joint venture, or agency relationship between the parties.
16. Except for mandamus and other special actions, no member, official or employee of the City shall be personally liable to Owner, or any successor in interest, in the event of any default or breach by the City or for any amount that may become due to the Owner or successor, or under any obligation under the terms of this Agreement.
17. Owner hereby certifies that it is not boycotting Israel.

IN WITNESS WHEREOF, the parties have executed this agreement through their authorized representatives as of this ____ day of _____, 2019.

City of San Luis, Arizona

Comite de Bienestar, Inc.

By: _____

By: _____

State of Arizona)

)ss.

County of Yuma)

The foregoing instrument was acknowledged before me this ____ day of _____, 2019, by Tadeo A. De La Hoya, City Manager of the City of San Luis, a municipal corporation of the State of Arizona, on behalf of the City.

Notary Public

My Commission Expires:

MEMORANDUM OF UNDERSTANDING
RE: Lot Split Case No. 2019-0113/Bienestar Estates 10
June 26, 2019
Page 4 of 4

State of Arizona)
)ss.
County of Yuma)

The foregoing instrument was acknowledged before me this ____ day of _____, 2019, by Gary Black, authorized representative of Comit  de Bienestar, Inc., an Arizona Corporation, on behalf of the corporation.

Notary Public

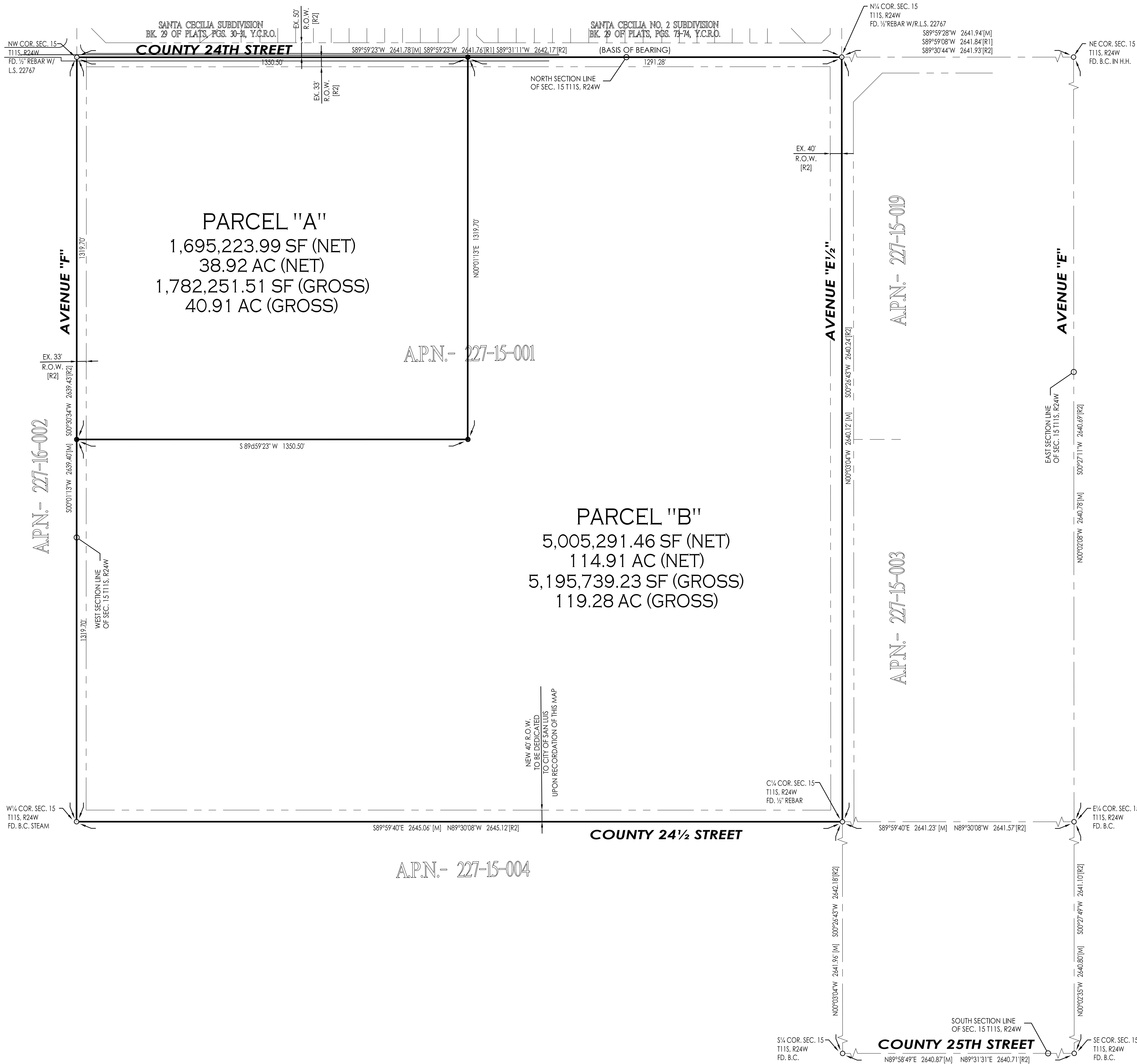
My Commission Expires:

BIENESTAR ESTATES 10 - LOT SPLIT

A Parcel Map of the Northwest Quarter Of Section 15,
T11S, R24W, G&S.R.B.&M. Yuma County Az.

T11S, R24W, G&S.R.B.&M. Yuma County Az.

Creating Parcels "A" & "B".



LEGEND

—	INDICATES BOUNDARY LINE
---	INDICATES CENTER LINE
- - - -	INDICATES RIGHT-OF-WAY LINE
- . - . -	INDICATES EASEMENT LINE
●	SET PROPERTY CORNERS TO BE MARKED BY 1/2" DIA. REBAR TAGGED WITH CAP L.S. 16528 (UNLESS NOTED OTHERWISE)
○	EXISTING MONUMENT (TYPE AS SHOWN)
B.C.	INDICATES BRASS CAP
Y.C.R.	INDICATES YUMA COUNTY RECORDERS
G.L.O.	INDICATES GENERAL LAND OFFICE
N.A.E.	INDICATES NON-ACCESS EASEMENT
PP	INDICATES POWER POLE
SS	INDICATES EXISTING SANITARY SEWER
(M)	INDICATES MEASURED DATA
(C)	INDICATES CALCULATED DATA
[R1]	DATA REFERS TO BORDER RANCHES SUBDIVISION, AS RECORDED IN BOOK 27 OF PLATS, PAGES 9 & 10, YUMA COUNTY RECORDERS OFFICE, YUMA COUNTY.
[R2]	DATA REFERS TO U.S.B.R. BALANCED SECTION OF SEC. 15, T11S, R24W, G&S.R.B.&M. YUMA COUNTY, AZ. DATED JUNE/1977.

LEGALDESCRIPTION

PARCEL "A"

A PORTION OF THE NW¼ OF SECTION 15, T11S, R24W, G&S.R.B.&M., YUMA COUNTY, ARIZONA MORE PARTICULARLY DESCRIBED AS FOLLOWS:

BEGINNING AT THE INTERSECTION OF CO. 24th STREET AND AVENUE F, BEING THE NW CORNER OF SAID SECTION 15 AND, ALSO BEING THE TRUE POINT OF BEGINNING;
THENCE N89°59'23"E ALONG THE NORTH SECTION LINE OF SAID SECTION 15 A DISTANCE OF 1,350.50' TO A POINT;
THENCE S00°01'13"W A DISTANCE OF 1319.70' TO A POINT;
THENCE S89°59'23"W A DISTANCE OF 1350.50' TO A POINT ON THE EAST SECTION LINE OF SAID SECTION 15;
THENCE ALONG SAID EAST SECTION LINE N00°01'13"E A DISTANCE OF 1319.70' TO THE TRUE POINT OF BEGINNING;

EXCEPT THE NORTH AND WEST 33.00' RIGHT OF WAY THEREOF;

SUBJECT TO ALL EASEMENTS OR RIGHT-OF-WAYS APPARENT OR RECORD.

CONTAINING 40.914 ACRES (1,782,251.51 SF) MORE OR LESS, GROSS
CONTAINING 38.916 ACRES (1,695,223.99 SF) MORE OR LESS, NET

PARCEL "B"

A PORTION OF THE NW¼ OF SECTION 15, T11S, R24W, G&S.R.B.&M., YUMA COUNTY, ARIZONA MORE PARTICULARLY DESCRIBED AS FOLLOWS:

BEGINNING AT THE INTERSECTION OF CO. 24th STREET AND AVENUE F, BEING THE NW CORNER OF SAID SECTION 15;
THENCE N89°59'23"E ALONG THE NORTH SECTION LINE OF SAID SECTION 15 A DISTANCE OF 1,350.50' TO THE TRUE POINT OF BEGINNING;
THENCE CONTINUING N89°59'23"E A DISTANCE OF 1291.28'
THENCE S00°03'04"E A DISTANCE OF 2440.12' TO A POINT;
THENCE N89°59'40"W A DISTANCE OF 2645.06' TO A POINT;
THENCE N00°01'13"E A DISTANCE OF 1319.70' TO A POINT;
THENCE N89°59'23"E A DISTANCE OF 1350.50' TO A POINT;
THENCE N00°01'13"E A DISTANCE OF 1319.70' TO THE TRUE POINT OF BEGINNING;

EXCEPT THE NORTH, EAST AND WEST 33.00' RIGHT OF WAY THEREOF;

SUBJECT TO ALL EASEMENTS OR RIGHT-OF-WAYS APPARENT OR RECORD.

CONTAINING 119.28 ACRES (5,005,291.46 SF) MORE OR LESS, GROSS
CONTAINING 114.91 ACRES (5,005,291.46 SF) MORE OR LESS, NET

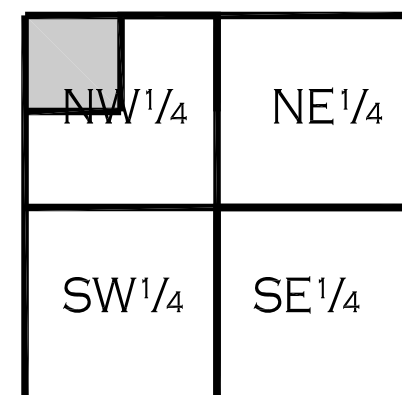
BASIS OF BEARING

THE NORTH LINE OF THE NW¼ OF SECTION 15, T11S, R24W, AS SHOWN ON BORDER RANCHES SUBDIVISION AS RECORDED IN BOOK 27 OF PLATS, PAGES 9&10, YUMA COUNTY RECORDERS OFFICE, YUMA COUNTY.

BEARING S89°59'23"W

NOTE

♦ PROPERTY CORNERS TO BE MARKED BY 1/2" DIAMETER REBAR TAGGED WITH CAP L.S. 16528



SEC. 15, T 11 S, R 24 W

LOCATIONMAP

BOOK _____, OF _____
PAGE _____

APPROVALS

APPROVED BY:

CITY OF SAN LUIS, PLANNING & ZONING DIRECTOR

CITY OF SAN LUIS, PUBLIC WORKS DIRECTOR

OWNER OF RECORD: (PARCEL "A")

COMITE DE BIENESTAR
PO BOX 7170
SAN LUIS, AZ. 85349

CARLOS SANCHEZ, PRESIDENT

ACKNOWLEDGMENT

STATE OF ARIZONA } SS
COUNTY OF YUMA }

THIS INSTRUMENT WAS ACKNOWLEDGED BEFORE ME THIS
____ DAY OF _____, 20____, BY CARLOS SANCHEZ

NOTARY PUBLIC

MY COMMISSION WILL EXPIRE _____

OWNER OF RECORD: (PARCEL B)

BORDER RANCHES AZ LLC
2921-B S KISH AVE
YUMA, AZ. 85365

JOSHUA J MEYER, MANAGER

ACKNOWLEDGMENT

STATE OF ARIZONA } SS
COUNTY OF YUMA }

THIS INSTRUMENT WAS ACKNOWLEDGED BEFORE ME THIS
____ DAY OF _____, 20____, BY JOSHUA J MEYER

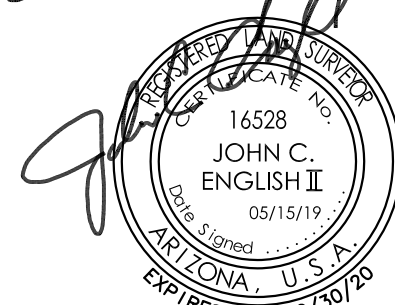
NOTARY PUBLIC

MY COMMISSION WILL EXPIRE _____

SURVEYOR'S CERTIFICATE

I HEREBY CERTIFY THAT I AM A LAND SURVEYOR LISTED ON THE ROSTER OF ACTIVE REGISTRANTS BY THE STATE BOARD OF TECHNICAL REGISTRATION OF ARIZONA AND THAT THIS MAP CONSISTING OF ONE (1) SHEET CORRECTLY REPRESENTS A SURVEY MADE UNDER MY SUPERVISION DURING APRIL OF 2019, THAT ALL MONUMENTS SHOWN HEREON ACTUALLY EXIST AND THEIR POSITIONS ARE CORRECTLY SHOWN.

BY: JOHN C. ENGLISH R.L.S. No. 16528





AGENDA ITEM REVIEW FORM

Special City Council Meeting

5.A.

Meeting Date: 06/25/2019

Department Head: Lizandro Galaviz, Director of Parks & Recreation, Parks & Recreation Department

Submitted By: Crystal Fragozo, Administrative Assistant, Parks & Recreation Department

Action Requested: Motion

ITEM:

Discussion and possible action on any and all matters regarding the City of San Luis offering to provide congregate meals nutrition services at the Senior Center in exchange for WACOG providing up to \$74,400.00 to support the service. **(Lizandro Galaviz, Director of Parks & Recreation)**

SUMMARY:

Somerton has had a contract with WACOG for both Somerton and San Luis to provide nutritious congregate meals at both Senior Centers. This year Somerton went out on its own and did not include San Luis in its bid for services. So this year, San Luis is offering to provide the services in exchange for up to \$74,400.00 in support from WACOG.

The offer is in development because WACOG's funding comes from government sources which have many specific requirements. The final written offer will be provided at the time of the meeting. The basic terms to be offered are as follows.

The City of San Luis will

- add a position for a safe serve certified cook with a minimum of thirty (30) hours per week to prepare nutritious meals for the members of the Senior Center,
- assign one part-time and two existing full-time staff so that part of their duties include serving congregate meals and the related clean-up at the Senior Center.

- report to WACOG on the implementation of the congregate meals nutrition program and

- provide the Senior Center and its amenities for the congregate meals nutrition program.

WACOG will pay up to \$74,400.00 at a rate of \$6.50 per meal served.

The duration will be one (1) year, renewable for five (5) years.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE THE OFFER TO WACOG AS PRESENTED AND AUTHORIZE THE DIRECTOR OF PARKS AND RECREATION TO ENTER INTO AN AGREEMENT WITH WACOG CONSISTENT WITH THIS OFFER.

Written Offer to be provided at the time of the meeting.

Fiscal Impact

IS THERE FISCAL IMPACT ASSOCIATED WITH THIS ITEM: N/A

CITY/STATE/FEDERAL FUNDS: N/A

TOTAL: N/A

BUDGETED AMOUNT: N/A

AVAILABLE AMOUNT TO TRANSFER: N/A

ACCT NAME & GL#/REMAINING BALANCE BEFORE PURCHASE: N/A

FISCAL IMPACT STATEMENT (IF THIS IS A BUDGET TRANSFER, YOU MUST ATTACH THE BUDGET ADJUSTMENT FORM):

This item is to continue the congregate meals nutrition program at the Senior Center by making a direct offer to WACOG rather than in coordination with Somerton. The program would be paid for by WACOG.



AGENDA ITEM REVIEW FORM

Special City Council Meeting

5.B.

Meeting Date: 06/25/2019

Department Head: Tadeo A. De La Hoya, City Manager, Administration

Submitted By: Fausto Gonzalez, HR Training & Programs Coordinator, Human Resources Department

Action Requested: Motion

ITEM:

Discussion and possible action on any and all matters regarding proposals from Border Gym Fitness, L.L.C. and 24/7 Get Fit Gym. **(Fausto Gonzalez, HR Training & Programs Coordinator)**

SUMMARY:

Because of the popularity of the city's Gym Membership Benefit Program (Gym Benefit), this year, Human Resources (HR) and the Wellness Committee are recommending the approval of the attached proposed contracts for Border Gym Fitness and 24/7 Get Fit Gym.

Success with adding the second gym contract

Memberships per gym have remained fairly consistent with memberships split in half between both providers for the past twelve months.

Border Gym Fitness Proposed Contract

Border Gym Fitness proposes a six-month contract ending December 31, 2019. The owners intend to return to the city before the expiration of the 6 months to negotiate a new contract for the next 6 months.

24/7 Get Fit Proposed Contract

24/7 proposes a one-year contract ending June 30, 2020. The city's Gym Benefit will cover the same services for all 3 locations (San Luis, Somerton, and the Foothills). Employees may purchase on their own the extra services available at the new Foothills gym. 24/7 membership will increase from \$19.99 per membership to \$22.00 per membership.

60 Gym Memberships

Since the increase from 50 memberships to 60, the Gym Benefit Program has maintained an average of 55 participants per month for the past 12 months.

Purpose

The Gym Benefit is part of the City's Wellness Program to

- *provide salutary options for employees,
- *encourage employees to become physically active in a non-work related environment, and
- *inspire employees to adopt and maintain healthy habits.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE THE CONTRACT WITH BORDER GYM FITNESS, THE CONTRACT WITH 24/7 GET FIT GYM, AND 60 GYM MEMBERSHIPS AS PRESENTED.

N/A

Fiscal Impact

IS THERE FISCAL IMPACT ASSOCIATED WITH THIS ITEM: Yes
CITY/STATE/FEDERAL FUNDS: CITY
TOTAL: 16840
BUDGETED AMOUNT: 16840
AVAILABLE AMOUNT TO TRANSFER: N/A
ACCT NAME & GL#/REMAINING BALANCE BEFORE PURCHASE: G/L ACCT #100-125-80005
SPECIAL SERVICES \$56,150
**FISCAL IMPACT STATEMENT (IF THIS IS A BUDGET TRANSFER, YOU MUST ATTACH THE
BUDGET ADJUSTMENT FORM):**
No budget transfer needed.

Attachments

Border Fitness Gym 6-Month Contract July - December 2019
Exhibit A - Border Fitness Access & Services
Enrollment Agreement Gym Benefit July-Dec 2019
247 Get Fit Gym Contract July 2019 -June 2020

AGREEMENT

This agreement (the "Agreement") is effective July 1, 2019, between the City of San Luis of P.O. Box 1170, San Luis, Arizona, 85349 ("City") and Border Gym Fitness, L.L.C., of P.O. Box 5107, 1938 E. Juan Sanchez Blvd, Suite 1, San Luis, Arizona, 85349 ("Contractor"). (The City and the Contractor may be referred to singularly as the "Party" and collectively as the "Parties").

A. The City is desirous of obtaining wellness health services.

B. Contractor agrees to perform these services for City under the terms and conditions set forth in this Agreement.

In consideration of the matters described above, and of the mutual benefits and obligations set forth in this agreement, the City and Contractor agree as follows:

SECTION ONE DESCRIPTION OF WORK

A. Gym Membership

The purpose of the Wellness Program shall be to help improve the overall fitness of employees of the City by providing gym membership with the Contractor for up to 60 City employees. Gym membership includes services as well as access to facilities and equipment as more fully described in Exhibit A, which is incorporated into this agreement by this reference. Contractor reserves the right to cancel any classes offered during the term of this Agreement without advance notice. The Contractor will not be responsible for providing audio equipment or any other special accommodations necessary for fitness activity participants, including but not limited to seating and water.

B. Equipment

Exercise equipment shall be in good working condition so that it may be operated safely and for the exercises for which the equipment was intended. For any equipment which is not in good working order as just described here, the Contractor shall restore it to good working order or replace it within twenty-one (21) days from the day it is no longer in good working condition.

C. Cleanliness

All locations of Contractor's gyms shall be clean, free of pests and air conditioning operational to the satisfaction of representatives of the City's H.R. Department and the Wellness Committee.

D. Invoicing

Contractor shall e-mail to the City every first Monday of every month its invoice for the previous month.

E. Reporting

Contractor shall report every month to the City the attendance of City Employees enrolled in the City's Gym Membership Benefit.

SECTION TWO PAYMENT

The City will pay Contractor \$22.00 per month per the number of City employees who are enrolled in the Gym Membership Benefit who use the services of the Contractor during that month for up to 60 employees during the term of this Agreement. Payment will be made on or before the 15th day of each month either by check or direct deposit to Contractor.

In addition, upon execution of this Contract, City will pay Contractor \$250.00 in advance for its administrative costs.

SECTION THREE RELATIONSHIP OF PARTIES

The parties intend that an independent contractor relationship will be created by this Agreement. The City is interested only in the results to be achieved and not the manner and means of achieving it. The conduct and control of the work will lie solely with Contractor. The Contractor is not to be considered an agent or employee of City for any purpose. The employees of Contractor are not to be considered agents or employees of the City. It is understood that City does not agree to use Contractor exclusively. It is further understood that Contractor is free to contract and provide similar services for others while under this Agreement with City.

SECTION FOUR LIABILITY

The work to be performed under this Agreement will be performed entirely at Contractor's risk, and Contractor assumes all responsibility for the condition of the premises and equipment used in the performance of this Agreement. The Contractor will carry, for the duration of this Agreement, public liability insurance in an amount

acceptable to City. Contractor agrees to indemnify City for any and all liability or loss arising in any way out of the performance of this Agreement.

SECTION FIVE EQUIPMENT

Contractor shall supply all equipment and supplies needed to perform this agreement without additional charge.

SECTION SIX DURATION

This Agreement shall begin on July 1, 2019, and terminate on December 31, 2019. Either party may cancel this Agreement on ten (10) days written notice; otherwise, the Agreement shall remain in force for its term. In the event of cancellation, no further monies will be owed by City to Contractor. Termination of any individual City Employee from City's Gym Benefit is determined by the Enrollment Agreement Exhibit B, which is incorporated into this agreement by this reference.

The Agreement may be renewed for an additional six months on the recommendation of the Wellness Committee, the City's HR Department and the approval of the City Council.

SECTION SEVEN MISCELLANEOUS

A. Notices

All notices to be given under this Agreement, or which may be given by either Party to the other, shall be considered validly given and fully received when made in writing and delivered or refused delivery by means of prepaid service by:

- deposit in the United States Postal Service by certified mail, return receipt requested, and postage prepaid,
- personal delivery by a process server or
- sent by a nationally recognized courier (e.g., Federal Express, UPS)

and addressed to the respective Parties as follows:

If to the CITY

**City Manager
City of San Luis
P.O. Box 1170 (by United States Postal Service)**

**1090 East Union Street (by personal process or courier)
San Luis, Arizona 85349**

**With a copy to San Luis City Attorney
The City of San Luis
P.O. Box 1170
San Luis, AZ 85349**

**If to the CONTRACTOR Luis Chang, Owner
P.O. Box 5107 (by United States Postal Service)
1938 E. Juan Sanchez Blvd.
Suite 1 (by personal process or courier)
San Luis, Arizona, 85349**

or such other addresses as either Party may from time to time designate in writing and deliver in a like manner. Any such change of address notice shall be given at least ten (10) days before the date on which the change is to become effective.

B. Waiver

No delay in exercising any right or remedy shall constitute a waiver thereof. The failure of either party to insist on the performance of any of the terms of this Agreement, or the waiver of any breach of any of the terms of this Agreement, shall not be construed as subsequently waiving any such terms, or any others, but the terms shall continue and remain in full force and effect as if no such forbearance or waiver had occurred.

C. Attorneys' Fees

In the event any Party finds it necessary to bring any action at law or other proceeding, including arbitration, against the other party to enforce any of the terms, covenants or conditions hereof, or by reason of any breach or default hereunder, the party prevailing in any such action or other proceeding shall be paid all reasonable costs and reasonable attorneys' fees by the other party, and in the event any judgment is secured by said prevailing party, all such costs and attorneys' fees shall be included therein, such fees to be set by the court and not by jury.

D. Counterparts

This agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. The signature pages from one or more counterparts may be removed from such counterparts and such signature pages all attached to a single instrument so that the signature of all parties may be physically attached to a single document.

E. Headings

The descriptive headings of the paragraphs of this agreement are inserted for convenience only and shall not control or affect the meaning or construction of any of the provisions hereof.

F. Time of the Essence

Time is of the essence in this Agreement.

G. No Agency, Partnership or Third Parties

It is not intended by this agreement to, and nothing contained in this agreement shall create any agency, partnership, joint venture or other similar arrangement between the Contractor and the City. No term or provision of this agreement is intended to, or shall, be for the benefit of any person, firm, organization or corporation not a party hereto, and no such other person, firm, organization or corporation shall have any right or cause of action hereunder.

H. Entire Agreement

This agreement constitutes the entire agreement between the parties hereto pertaining to the subject matter hereof. All prior and contemporaneous agreements, representations and understandings of the parties, oral or written, are hereby superseded and merged herein.

I. Amendment

No change or additions are to be made to this agreement except by a written amendment executed by the parties hereto.

J. Governing Law

This Agreement is entered into in Arizona and shall be construed and interpreted under the laws of the State of Arizona.

K. Compliance with the Law and Provisions Required by Arizona Law

The Contractor agrees it will comply with all federal, state and local laws including but not limited to:

- (1) Contractor certifies that it does not participate in, and agrees not to participate in during the term of the contract a boycott of Israel in accordance with A.R.S. §35-393.01. I understand that my entire response will become public record in accordance with A.A.C. R2-7-C317,
- (2) Contractor certifies that pursuant to A.R.S. §41-4401(A), the undersigned is authorized to and does warrant its compliance with all federal immigration

laws and regulations that relate to its employees and its compliance with A.R.S. § 23-214, subsection A, E-verify. A breach by the undersigned or his/her employer of this warranty shall be deemed a material breach of the contract that is subject to penalties up to and including termination of the contract. The City retains the legal right to inspect the papers of any contractor or subcontractor employee who works under this Agreement to ensure that the undersigned, his/her employer or the employer's subcontractor or subcontractors are complying with this warranty.

- (3) Notice of A.R. S. §38-511: Conflict of Interest. Pursuant to Arizona law, rules and regulations, no member, official or employee of the City shall have any personal interest, direct or indirect in this Agreement, nor shall any such member, official or employee participate in any decision relating to this Agreement which affects his or her personal interest or the interest of any corporation, partnership or association in which he or she is, directly or indirectly, interested. This agreement is subject to the provisions of A.R.S. §38-511.

L. Venue

Any legal action relating to this agreement shall be brought in either court of competent jurisdiction in Yuma County, Arizona or in the United States District Court for the District of Arizona at the election of the plaintiff in such legal action, provided, however, that nothing in this paragraph will be deemed to have authorized the bringing of any legal action in a court which does not otherwise have jurisdiction to adjudicate the legal action.

M. Severability

Every provision of this agreement is and will be construed to be, a separate and independent covenant. If any provision of this agreement or the application of the same is, to any extent, found to be invalid or unenforceable, then the remainder of this agreement or the application of that provision to circumstances other than those to which it is invalid or unenforceable, will not be affected by that invalidity or unenforceability, and each provision of this agreement will be valid and will be enforced to the extent permitted by the law, and the parties will negotiate in good faith for such amendments of this agreement which may be necessary to achieve its intent, notwithstanding such invalidity or unenforceability.

N. No Personal Liability

No member, official or employee of the City shall be personally liable to Contractor, or any successor or assignee, (a) in the event of any default or breach by the City, (b) for any amount which may become due to the Contractor or its successor or assign, or (c) pursuant to any obligation of the City under the terms of this Agreement.

O. Business License

Contractor shall obtain and maintain during the term of this Agreement a City business license.

P. Authority

The undersigned represent to each other that they have full power and authority to enter into this Agreement and that all necessary actions have been taken to give full force and effect to this Agreement.

Q. Notice of Conveyance or Assignment

The Contractor shall give notice to the City of any sale of Contractor's gym business at least 10 days prior to the effective date of the sale. The Contractor may assign all of its rights under this Agreement to any one or more persons or entities, on such terms as Contractor may deem appropriate, provided that Contractor may not convey said rights unless the corresponding obligations of the Contractor are assumed by the assignee of the Contractor's rights. Notice of the assignment of rights and assumption of obligations shall be in a document signed by the Contractor and such assignee. Contractor shall be released from the obligations assumed by the assignee once the City receives notice under the notice requirements of the Agreement.

[Intentionally left blank, signature page follows]

The Parties have executed this Agreement as of the dates below.

BORDER GYM FITNESS, L.L.C.

by _____ Date _____
Luis Chang, Owner

CITY OF SAN LUIS, ARIZONA

Gerardo Sanchez, Mayor

Date

ATTEST:

APPROVED AS TO FORM:

Sonia Cornelio, City Clerk

Kay Marion Macuil, City Attorney

Exhibit A

Border Gym Fitness L.L.C

Locations:

1938 Juan Sanchez Blvd Suite 1 & 2
San Luis, Arizona

240 W. Main St.
Somerton, Arizona

Access and Services:

Access to open gym and exercise equipment 24 hours per day, 7 days per week at both locations;

Classes at the San Luis location only (Zumba, Yoga, Spinning, Cross-Training and Cardio Boxing, all of which are subject to change or cancellation without notice);

Three (3) scheduled free orientations with a trainer which includes instruction on how to use each of our machines;

30-minute circuit;

Kids-care area Monday through Thursday from 6 p.m. to 8 p.m. ; and

Kids-rest area in Somerton.

BORDER GYM FITNESS**Employee's Agreement for Gym Membership Benefit July – December 2019****Acuerdo del Empleado(a) Para Beneficio de membresía de Gimnasio – julio – diciembre 2019****Purpose / Propósito**

For the purpose of promoting a healthy workforce, the City of San Luis, Arizona (further referred to as "City") wishes to provide voluntary gym membership free of charge to its full-time, non-temporary, non-seasonal employees.

Con el propósito de promover una fuerza laboral saludable, la Ciudad de San Luis, Arizona (de aquí en adelante referida como "Ciudad") desea proveer, a los empleados que así lo deseen, una membresía libre de costo a los empleados de tiempo completo, pero no a empleados temporales ni estacionales.

Agreement / Acuerdo

By signing below, I verify, understand and agree that:

Al firmar, verifico, entiendo y estoy de acuerdo que:

1. I am a full-time, non-temporary, non-seasonal employee of the City of San Luis, Arizona.
Soy empleado(a) de tiempo completo, no temporal ni estacional de la Ciudad de San Luis, Arizona.
2. This gym membership is voluntary and is offered for my personal benefit and it is not related to my work duties or functions.
Esta membresía del gimnasio es voluntaria y se ofrece para mi beneficio personal y no tiene relación alguna con mis funciones o deberes laborales.
3. If I am injured in the scope of using this Gym benefit, I understand I am not covered by City of San Luis workers' compensation insurance benefit.
Si me lesiono en uso del beneficio del gimnasio, entiendo que no estoy cubierto por el beneficio del seguro de compensación para trabajadores de la ciudad de San Luis.
4. Gym membership is offered through **Border Gym Fitness** which has facilities in Somerton and San Luis, Arizona.
La membresía del gimnasio es ofrecida a través de Border Gym Fitness, el cual tiene instalaciones en Somerton y San Luis, Arizona.
5. Border Gym Fitness is a third-party, independent contractor and it is not to be considered an agent, representative, or employee of the City for any purpose.
Border Gym Fitness es un contratista tercero e independiente y no debe ser considerado un agente, representante, o empleado de la Ciudad.
6. The City assumes no responsibility for the premises, equipment, or employees of Border Gym Fitness for any reason or purpose, whatsoever.
La Ciudad no asume ninguna responsabilidad por las instalaciones, el equipo, o empleados de Border Gym Fitness por cualquier motivo o finalidad, en absoluto.
7. Border Gym Fitness might cancel any classes offered during the term of the membership without advanced notice. Note: Classes only available in San Luis facility.
Border Gym Fitness reserva el derecho de cancelar cualquiera de las clases que ofrezca durante el término de la membresía sin previa notificación previo aviso. Nota: Clases solo disponibles en el local de San Luis.
8. I agree to attend Border Gym Fitness at least 8 times per calendar month unless my absence is excused through the Human Resources Department of the City (HR).
Me comprometo asistir a Border Gym Fitness por lo menos 8 veces por mes, a menos de que mi ausencia sea justificada por el Departamento de Recursos Humanos de la Ciudad (referido de aquí en adelante como "HR").

9. I understand that if I fail to attend Border Gym Fitness at least 8 times in one calendar month without an excuse accepted by HR then I will be suspended from the program the next calendar month. After the month of suspension, I may apply for the Gym Benefit.
Entiendo que si no cumplo con mi asistencia a Border Gym Fitness por lo menos 8 veces en un mes sin una razón que haya sido justificada por HR, seré suspendido del programa por un mes. Al cumplir con el mes de suspensión, puedo solicitar el beneficio del Gimnasio.
10. I understand that HR has the sole reasonable discretion to excuse my non-attendance at Border Gym Fitness.
Entiendo que HR usará una discreción razonable para justificar mi falta de asistencia a Border Gym Fitness.
11. I understand that the City cannot exceed 60 memberships per month by contract with Border Gym Fitness. I understand that HR must take into consideration this limit on membership when deciding whether to excuse non-attendance.
Entiendo que la Ciudad de San Luis no puede exceder el límite de 60 membresías por mes especulado en el contrato con Border Gym Fitness. Entiendo que HR debe tener en cuenta este límite de membresías a la hora de decidir si se debe excusar la falta de asistencia.
12. I understand that HR has the sole reasonable discretion to permanently terminate my gym benefit or require me to reimburse the City for the cost of my benefit if I am not using my gym benefit to participate in fitness activities.
Entiendo que HR usará discreción razonable sobre la cancelación permanente del uso del beneficio o exigirme que reembolse a la ciudad por el costo del beneficio de gimnasio si no participo en actividades de acondicionamiento físico.
13. I agree that I must contact HR immediately to request to be excused from attendance. If I do not contact HR immediately, HR will not consider my request after the first business day of the following month of my absence. (For example: if an employee couldn't go to the gym at least 8 times in July because the employee was sick, the employee must contact HR to be excused, no later than first Monday in August.)
Estoy de acuerdo en comunicarme con HR inmediatamente para solicitar una justificación por cualquier ausencia. Si no me comunico con HR inmediatamente, HR no considerará mi solicitud después del primer día laboral del mes siguiente de mi ausencia. (Por ejemplo: si un empleado(a) no puede ir al gimnasio por lo menos 8 veces en Julio porque el empleado(a) estaba enfermo(a), el empleado(a) deberá de comunicarse con HR para solicitar un justificante que no pase del primer Lunes de Agosto).
14. My free membership benefit through Border Gym Fitness continues until December 31, 2019 unless it is terminated sooner because I am no longer employed through the City of San Luis, or I failed to follow the rules of Border Gym Fitness, or I failed to attend *Border Gym Fitness* at least 8 times per month without an excuse accepted by HR.
Mi beneficio de membresía gratuita a través de Border Gym Fitness continuará hasta el 31 de diciembre del 2019, a menos de que sea terminada antes porque ya no estoy empleado(a) por la Ciudad de San Luis, o porque no seguí las reglas de Border Gym Fitness, o dejé de ir al Border Gym Fitness por lo menos 8 veces al mes sin justificación alguna que no haya sido aprobada por HR.
15. I understand that it will be employee's responsibility to pay \$20.00 for proxy key to Border Gym Fitness, if I request one.
Entiendo que sera la responsabilidad del empleado de pagar \$20 por una llave electronica a Border Gym Fitness, si yo la solicito.

Employee Signature / Firma De Empleado(a)

Date/Fecha

Print Employee Name / Nombre De Empleado(a) Por Escrito



**CORPORATE AGREEMENT BETWEEN
24-7 GET FIT SL, LLC and THE CITY OF SAN LUIS**

This Agreement is made and entered into this 13th day of June 2019, by and between 24-7 GET FIT SL, LLC, Contractor (hereinafter "GET FIT"), an Arizona Limited Liability Company operating at 1922 E Juan Sanchez Blvd, in San Luis, Arizona and The City of San Luis, Customer (hereinafter "CITY") located at 1090 E. Union Street, in San Luis, Arizona.

RECITALS:

A. That CITY and GET FIT agree to all the terms and conditions hereinafter set forth.

B. That this is the renewal contract between GET FIT and CITY.

NOW, THEREFORE, in consideration of the mutual promises, the parties agree as follows:

1. The recitals are hereby incorporated by reference as agreements of the parties.
2. That the term of this Agreement shall be for the period of twelve (12) months, commencing on July 1st, 2019, and ending on June 30th, 2020.
3. CITY agrees to keep the FIVE HUNDRED US DOLLARS (\$500.00) refundable deposit with GET FIT. If the CITY is not in default, then the deposit will be refunded at the end of the term of this contract, applied to account balance, or rolled over to the next contract at the CITY's request.
4. CITY's corporate account must maintain at a minimum 15 GET FIT club members at all time or otherwise fees will be deducted from deposit as per paragraph 5.
5. If CITY does not maintain the minimum required 15 members, then CITY agrees that the difference in the total monthly fee (15 member fees minus actual fees) will be deducted from the \$500.00 deposit on a month to month basis. At the end of the term of this agreement, GET FIT will refund the remaining balance of the deposit to the CITY as per paragraph 2. Under no circumstances, the difference in monthly fees over the twelve-month term will exceed the \$500 Deposit.
6. If CITY cancels the contract before June 30th, 2020 then CITY is hereby waiving its right to the \$500.00 deposit and NO refund will be issued.
7. GET FIT will issue gym memberships to CITY employees under CITY's corporate account and provide access to the facility as per GET FIT policies. Employees will have single membership benefits to all 24-7 Get Fit clubs. Please refer to exhibit A for plan membership benefits.
8. CITY agrees to pay the dues on behalf of its employees.
 - A- CITY agrees to pay an upfront, non-refundable \$500 yearly administration fee to be billed on July 1st, 2019 and paid no later than July 20th, 2019. The administration fee is not refundable under any circumstances.
 - B- GET FIT agrees to waive the enrollment fee, the key card cost, and the pro-rated monthly dues for the initial month. The cost to join will only be the monthly dues.
 - C- The monthly membership fee is \$22.00 per person.

- D- CITY agrees to issue a check for the full amount to GET FIT no later than the 20th day of each month for the total dollar amount due for the administration fee, memberships and signups under the corporate account. If payment is not received by the 20th of each month, the City agrees to pay a late charge fee of \$25 every month the payment is late.
9. CITY agrees that if a payment is returned for insufficient funds, or rejected due to a closed account, an NSF fee of \$25.00 will be applied to the account.
10. If CITY fails to pay any amount when due under this agreement, GET FIT shall be entitled, anytime and in its sole discretion, to suspend or cancel the corporate account and the employees memberships and to require CITY to immediately pay all past due balances. Suspension or cancellation shall not relieve CITY from the obligation to pay any unpaid balances. Any payments owing from CITY to GET FIT that are not received when due shall bear interest at 10% per annum. If CITY fails to pay any amount to GET FIT when due, CITY shall pay all costs and expenses incurred by GET FIT to collect the unpaid balance, including reasonable attorney's fees and expenses.
11. CITY understands that each of its employees will sign a separate membership agreement with GET FIT to adhere and comply with the company's rules and regulations as they may thereafter be modified, amended or supplemented. The separate membership agreement entails GET FIT's policies including but not limited to health representation, guest policy, waiver of liability and hold harmless agreement.
12. CITY is responsible to notify GET FIT if an employee is terminated. Once notice is received, GET FIT will remove terminated employees from the corporate account.
13. GET FIT will e-mail monthly the City's HR Department the invoice and a report detailing all active corporate members with visit count, and the previous month new members.
14. If any dispute or disagreement arises with respect to any provision of this agreement or the performance of either party under the agreement, the dispute or disagreement shall be settled by arbitration, to which the parties bind themselves as follows:

15. This Agreement constitutes the entire Agreement between the parties and may not be amended except by a writing signed by each of the parties.
16. This Agreement shall be construed under the laws of the State of Arizona.
17. The signer for both parties represent that it has full power, authority and legal right to execute and deliver this contractual agreement.
18. Miscellaneous covenants
 - A- Notices.

If to the CITY: City Manager
City of San Luis

P.O. Box 1170 (by United States Postal Service)
1090 East Union Street (by personal process or courier)
San Luis, Arizona 85349

With a copy to: San Luis City Attorney
The City of San Luis
P.O. Box 1170
San Luis, AZ 85349

If to the CONTRACOR: Scott Awar
P.O. Box 736 (by United States Postal Service)
Somerton, AZ 85350

1922 E. Juan Sanchez Blvd.
Suite 6 (by personal process or courier)
San Luis, Arizona, 85349

or such other addresses as either party may from time to time designate in writing and deliver in a like manner. Any such change of address notice shall be given at least ten (10) days before the date on which the change is to become effective. Notices, approvals, changes of addresses and other communications provided for herein shall be effective upon receipt as hereinabove provided, prepaid and addressed as set forth above.

B- Waiver.

No delay in exercising any right or remedy shall constitute a waiver thereof. The failure of either party to insist on the performance of any of the terms of this Agreement, or the waiver of any breach of any of the terms of this Agreement, shall not be construed as subsequently waiving any such terms, or any others, but the terms shall continue and remain in full force and effect as if no such forbearance or waiver had occurred.

C- Attorneys' Fees.

In the event any party finds it necessary to bring any action at law or other proceeding, including arbitration, against the other party to enforce any of the terms, covenants or conditions hereof, or by reason of any breach or default hereunder, the party prevailing in any such action or other proceeding shall be paid all reasonable costs and reasonable attorneys' fees by the other party, and in the event any judgment is secured by said prevailing party, all such costs and attorneys' fees shall be included therein, such fees to be set by the court and not by jury.

D- Counterparts.

This agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. The signature pages from one or more counterparts may be removed from such counterparts and such signature pages all attached to a single instrument so that the signature of all parties may be physically attached to a single document.

E- Headings.

The descriptive headings of the paragraphs of this agreement are inserted for convenience only and shall not control or affect the meaning or construction of any of the provisions hereof.

F- Time of the Essence.

Time is of the essence of this Agreement.

G- No Partnership and Third Parties.

It is not intended by this agreement to, and nothing contained in this agreement shall, create any partnership, joint venture or other similar arrangement between Get Fit and City. No term or provision of this agreement is intended to, or shall, be for the benefit of any person, firm, organization or corporation not a party hereto, and no such other person, firm, organization or corporation shall have any right or cause of action hereunder.

H- Entire Agreement.

This agreement constitutes the entire agreement between the parties hereto pertaining to the subject matter hereof. All prior and contemporaneous agreements, representations and understandings of the parties, oral or written, are hereby superseded and merged herein.

I- Amendment.

No change or additions are to be made to this agreement except by a written amendment executed by the parties hereto.

J- Governing Law.

This agreement is entered into in Arizona and shall be construed and interpreted under the laws of the State of Arizona.

K- Arizona Laws.

- i. Get Fit certifies that it does not participate in, and agrees not to participate in during the term of the contract a boycott of Israel in accordance with A.R.S. §35-393.01. I understand that my entire response will become public record in accordance with A.A.C. R2-7-C317,
- ii. Get Fit certifies that pursuant to A.R.S. §41-4401(A), the undersigned is authorized to and does warrant its compliance with all federal immigration laws and regulations that relate to its employees and its compliance with A.R.S. § 23-214, subsection A, e-verify. A breach by the undersigned or his/her employer of this warranty shall be deemed a material breach of the contract that is subject to penalties up to and including termination of the contract. The City retains the legal right to inspect the papers of any contractor or subcontractor employee who works under this Agreement to ensure that the undersigned, his/her employer or the employer's subcontractor or subcontractors are complying with this warranty.
- iii. **Notice of A.R. S. §38-511:** Conflict of Interest. Pursuant to Arizona law, rules and regulations, no member, official or employee of the City shall have any personal interest, direct or indirect in this Agreement, nor shall any such member, official or employee participate in any decision relating to this Agreement which affects his or her personal interest or the interest of any corporation, partnership or association in which he or she is, directly or indirectly, interested. This agreement is subject to the provisions of A.R.S. §38-511.

L- Venue.

Any legal action relating to this agreement shall be brought in either court of competent jurisdiction in Yuma County, Arizona or in the United States District Court for the District of Arizona at the election of the plaintiff in such legal action, provided, however, that nothing in this paragraph will be deemed to have authorized the bringing

of any legal action in a court which does not otherwise have jurisdiction to adjudicate the legal action.

M- Severability.

Every provision of this agreement is, and will be construed to be, a separate and independent covenant. If any provision of this agreement or the application of the same is, to any extent, found to be invalid or unenforceable, then the remainder of this agreement or the application of that provision to circumstances other than those to which it is invalid or unenforceable, will not be affected by that invalidity or unenforceability, and each provision of this agreement will be valid and will be enforced to the extent permitted by the law, and the parties will negotiate in good faith for such amendments of this agreement which may be necessary to achieve its intent, notwithstanding such invalidity or unenforceability.

N- No Personal Liability.

No member, official or employee of the City shall be personally liable to Get Fit, or any successor or assignee, (a) in the event of any default or breach by the City, (b) for any amount which may become due to Get Fit or its successor or assign, or (c) pursuant to any obligation of the City under the terms of this Agreement.

O- Business License.

Get Fit shall obtain and maintain during the term of this Agreement a City business license.

The parties have executed this agreement on the day and year first above written.

24-7 GET FIT SL, LLC

CITY OF SAN LUIS

by _____
S. Scott Awar, President

by _____
Gerardo Sanchez, Mayor

ATTEST:

APPROVED AS TO FORM:

Sonia Cornelio, City Clerk

Kay Marion Macuil, City Attorney

Exhibit A

Membership Plan Benefits

- Single Membership: Allows member access to any 24-7 Get Fit Club and use of the facility. Membership excludes any add-ons such as premium package or Fit Kids Club. Please see Club for details.
- Joint Membership: Membership offered for couples living at the same address. Membership allows both members access to any 24-7 Get Fit Club and use of the facility. Membership excludes any add-ons such as premium package or Fit Kids Club. Please see Club for details.
- Family Membership: Membership offered for families. It includes 2 adults and 2 kids between the ages of 13 and 17. Membership allows all 4 members' access to any 24-7 Get Fit Club and use of the facility. Membership excludes any add-ons such as premium package or Fit Kids Club. Please note that minors do not receive entry tokens and are not allowed to work out without parent supervision. Please see Club for details.
- Fit Kids Club Add-on: Service to watch your child/ children while you are using the facility. Service is limited to 2 hours per day during Fit Kids Club hours. Each child is \$10 per month. Please note that if membership is canceled or Fit Kids Club service is removed from member's account, no further services will be provided after cancellation or downgrade and no further fees will be charged upon notice of cancellation or downgrade.
- Premium Package: Varies by club, please see club for rules and details. Some of the benefits are access to tanning bed, massage bed, Beauty Angel and classes such as Yoga, Zumba, kickboxing, etc. Please note that if membership is canceled or Premium Package is removed from member's account, no further services will be provided after cancellation or downgrade and no further fees will be charged upon notice of cancellation or downgrade.



AGENDA ITEM REVIEW FORM

Special City Council Meeting

5.C.

Meeting Date: 06/25/2019

Department Head: Kay Macuil, City Attorney, Attorney's Office

Submitted By: Kay Macuil, City Attorney, Attorney's Office

Action Requested: Motion
Order

ITEM:

Discussion and possible action on any and all matters regarding Order No. 2019-5. An order of the Mayor and City Council of the City of San Luis, Arizona implementing a uniform video and cable service license, a standard form application with an affidavit by mandate of the Arizona Legislature. (ITEM CONTINUED FROM REGULAR COUNCIL MEETING HELD MAY 22, 2019) **(Kay Marion Macuil, City Attorney)**

SUMMARY:

Reason for continuing the item

At the May 22, 2019, the City Attorney requested that this item be continued because there was discussion among Arizona City Attorneys on the topic that warranted more investigation. The discussion was about creating a supporting ordinance. As of the writing of this Agenda Item, the City Attorney's Office is still looking into whether such an ordinance it makes sense for San Luis.

Background on this Item

On May 16, 2018, Governor Ducey of Arizona signed into law SB1140 which requires that cities adopt by July 1, 2019, a uniform video and cable service license agreement along with a standard application and affidavit to obtain the license agreement. A telecommunications work-group developed the forms staff has provided for adoption. The cable industry has accepted them. The forms track SB1140, and they take into account HB2229 and HB2179 passed in April and May this year.

For more information, staff has attached an article and excerpts of two (2) reports by the League of Arizona Cities and Towns further explaining the law and the three (3) bills involved.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE AND ADOPT ORDER NO. 2019-5.

N/A

Fiscal Impact

IS THERE FISCAL IMPACT ASSOCIATED WITH THIS ITEM:	No
CITY/STATE/FEDERAL FUNDS:	N/A
TOTAL:	N/A
BUDGETED AMOUNT:	N/A
AVAILABLE AMOUNT TO TRANSFER:	N/A

ACCT NAME & GL#/REMAINING BALANCE BEFORE PURCHASE: N/A

FISCAL IMPACT STATEMENT (IF THIS IS A BUDGET TRANSFER, YOU MUST ATTACH THE BUDGET ADJUSTMENT FORM):

There is no discernible fiscal impact. There will be only an administrative change.

Attachments

Order No. 2019-5

Model Cable Service Agreement

Standard Application & Affidavit for Agreement

League Article

League 2018 New Law Report

League 2019 New Laws & Implementation

SB1140

HB2229

HB 2179



Order

OFFICE OF THE
MAYOR
CITY OF SAN LUIS

No. 2019-5

AN ORDER OF THE MAYOR AND CITY COUNCIL OF THE CITY OF SAN LUIS, ARIZONA IMPLEMENTING A UNIFORM VIDEO AND CABLE SERVICE LICENSE, A STANDARD FORM APPLICATION WITH AN AFFIDAVIT BY MANDATE OF THE ARIZONA LEGISLATURE.

IT IS ORDERED by the Mayor and City Council of the City of San Luis, Arizona, as follows:

Section 1. Under SB1140 signed into Arizona law on or about May 16, 2018, the City of San Luis shall implement the Model Uniform Video Service License Agreement and the standard Application and Affidavit for Uniform Video Service License which are attached to this order and incorporated into this order by this reference as though fully set forth again in full.

Section 2. The various city officers and employees are authorized and directed to perform all acts necessary or desirable to give effect to this order.

PASSED AND ADOPTED by the Mayor and City Council of the City of San Luis, Arizona this _____ day of May, 2019

Gerardo Sanchez, Mayor

ATTEST:

APPROVED AS TO FORM:

Sonia Cornelio, City Clerk

Kay Macuil, City Attorney

Model Uniform Video Service License Agreement

Date of Issuance: _____

This Uniform Video Service License Agreement ("License") is made on the date of issuance hereof by and between the City of San Luis, an Arizona municipal corporation ("Licensor") and _____, a _____ ("Licensee").

WHEREAS, Licensee has filed a completed application and affidavit under Title 9, Chapter 13, Arizona Revised Statutes ("Licensing Statute"), for Licensor to issue a Uniform Video Service License to Licensee; and

WHEREAS, Licensee is authorized under the laws of the State of Arizona to provide Cable Service.

NOW THEREFORE, in consideration of the foregoing recitals, which are incorporated herein and the mutual covenants set forth herein, the Parties agree as follows:

1. Definitions. Capitalized terms that are not defined herein have the same meaning prescribed in the Licensing Statute, including A.R.S. Section 9-1401.

2. Licensee Information. The following appear on Exhibit A attached hereto and are incorporated herein by this reference:

2.1 The name of Licensee, its type of entity and its jurisdiction of formation.

2.2 The address and telephone number of Licensee's principal place of business.

2.3 The names, titles and addresses of Licensee's principal executive officers or general partners.

2.4 The names, titles, telephone and fax numbers and email addresses of any persons authorized to represent Licensee before Licensor.

3. Grant of License. Under the Licensing Statute, Licensor hereby issues to Licensee, and Licensee hereby accepts from Licensor, a nonexclusive Uniform Video Service License.

3.1 The Service Area in which this License authorizes Licensee to provide Video Service in the area described on Exhibit B attached hereto and incorporated herein by this reference.

3.2. Licensor grants Licensee authority in the delivery of Video Service to use and occupy, and to construct and operate a Video Service Network in, Highways in the Service Area in compliance with the Licensing Statute and this License .

3.3 Licensee may operate and maintain facilities installed in the Highways in the Service Area to provide services pursuant to and subject to all the following: A.R.S. Section 9-584 and A.R.S. Title 9, Chapter 5.

4. Licensee Compliance with Law. Licensee shall comply with and be subject to:

4.1 All valid and enforceable federal and state laws.

4.2 All generally applicable, nondiscriminatory Local Laws, including highway use, mapping, insurance, performance bonds, security fund, indemnification, letter of credit or similar requirements that apply to the use and occupation of any highway and that conform to the Licensing Statute.

4.3 All public, education and government programming requirements of the Licensing Statute.

4.4 All customer service rules of the Federal Communications Commission under 47 Code of Federal Regulations Section 76.309(c) applicable to Cable Operators.

4.5 All consumer privacy requirements of 47 United States Code Section 551 applicable to Cable Operators.

5. Commencement of Video Service; Revocation. If Licensee is an incumbent cable operator, Licensee shall begin to provide Video Services under this License on the date of issuance of this license. If Licensee is not an incumbent cable operator, Licensee shall provide video service to at least one subscriber within each service area authorized by this License not later than twenty-four months after the date of issuance of this License. Failure of a non-incumbent cable operator to provide video service to at least one subscriber within each service area as set forth above shall result in revocation of this License unless the Licensee establishes to the satisfaction of the City/Town that such failure was for reasons beyond the Licensee's control.

6. License Fee. Licensee is required to pay the License Fees required under the Licensing Statute and all other lawful fees, taxes and charges imposed by Licensor. The initial rate of the License Fee shall be [five (5)] percent.

7. Federal Filing Requirement. Licensee is required to file in a timely manner with the Federal Communications Commission all forms required by that agency before Licensee offers Video Service in the Service Area, including the forms required by 47 Code of Federal Regulations Section 76.1801.

8. Term. The term of this License is ten (10) years and shall begin on the date of issuance.

9. Compliance with Law. Licensor and Licensee agree that they are subject to and must comply with the Licensing Statute. This License is subject to A.R.S. Section 38-511.

Licensor

Licensee

City of San Luis, an Arizona municipal corporation

By: _____
Its: _____
Date: _____

By : _____
Its: _____
Date: _____

ATTEST:

City Clerk

APPROVED AS TO FORM:

City Attorney

STATE OF _____)
County of _____) ss.

The foregoing instrument was acknowledged before me this _____ day of _____, 20__ by _____, the _____ of _____, a _____ on behalf of Licensee.

(Seal)

Notary Public

STATE OF ARIZONA)
) ss.
County of Yuma)

The foregoing instrument was acknowledged before me this _____ day
of _____, 20__ by _____, Mayor of the City of San Luis, an
Arizona municipal corporation, on its behalf.

(Seal)

EXHIBIT A

[Information about Licensee]

I. Licensee:

Date:		
Applicant's Name:		
Principal Place of Business		
Phone:	Address:	
City:	State:	Zip:
Type of Entity:	Jurisdiction of Formation:	Email:

II. Licensee's principal executive officers or general partners:

Name:	Title:
Address:	

Name:	Title:
Address:	

Name:	Title:
Address:	

Name:	Title:
Address:	

III. Person(s) authorized to represent Licensee before Local Government:

Name:	Title:	
Address:		
Phone:	Fax:	Email:

Name:	Title:	
Address:		
Phone:	Fax:	Email:

Name:	Title:	
Address:		
Phone:	Fax:	Email:

EXHIBIT B
[Service Area]

APPLICATION AND AFFIDAVIT FOR UNIFORM VIDEO SERVICE LICENSE

(Pursuant to Title 9, chapter 13, Arizona Revised Statutes)

Local Government: City of San Luis**I. Applicant:**

Date:		
Applicant's Name:		
Principal Place of Business:		
Phone:	Address:	
City/Town:	State:	Zip:
Type of Entity:	Jurisdiction of Formation:	Email:

II. Applicant's principal executive officers or general partners:

Name:	Title:
Address:	

Name:	Title:
Address:	

Name:	Title:
Address:	

Name:	Title:
Address:	

III. Person(s) authorized to represent Applicant before Local Government:

Name:	Title:	
Address:		
Phone:	Fax:	Email:

Name:	Title:	
Address:		
Phone:	Fax:	Email:

IV. Check one pursuant to Arizona Revised Statutes Section 9-1411(C)(4):

- ☐ Applicant is an Incumbent Cable Operator as provided in Arizona Revised Statutes, Section 9-1401(13).
- ☐ Applicant is not an Incumbent Cable Operator. The date on which the Applicant expects to provide Video Services in the Service Area identified below under Section 9-1411(C)(5) is:

Date:

V. For All Applications:

- A. Applicant will timely file with the Federal Communications Commission all forms required by that agency before Applicant offers Video Service in the Service Area, including the forms required by 47 Code of Federal Regulations Section 76.1801.
- B. The term of the uniform video service license shall be (not to exceed ten years):
- | |
|-------|
| Years |
|-------|
- C. Applicant agrees to pay all lawful fees and charges imposed by Local Government as provided in Arizona Revised Statutes, Section 9-1414(B)(4).
- D. Applicant agrees to notify Local Government in writing of changes to the above information within thirty days after the change occurs as provided in Arizona Revised Statutes, Section 9-1414(B)(2).
- E. Provide an exact description of the Service Area as set forth in Arizona Revised Statutes, Section 9-1411(C)(5), as identified by a geographic information system digital boundary meeting or exceeding national map accuracy standards.

Select one:

The Service Area consists of all the territory within the Boundaries of Local Government:

The Service Area consists of all the territory within the area described on attached Exhibit A.

Applicant Verification

I certify that the information contained in this application for a video service license in the [City/Town] of _____ is true and correct. I further affirm that I am authorized by _____ [NAME OF APPLICANT] to file this application on behalf of applicant and to bind the applicant with respect to the representations made in Section V, Paragraphs A through D of this application. A copy of the authorization is attached to this application.

Name and Title (printed):

Signature:

Date:

Local Government Receipt

The foregoing Application and Affidavit for Uniform Video Service License was received by Local Government this _____ day of _____, 20____; at _____.

City of San Luis, an Arizona municipal corporation ("Local Government")

By _____

Print Name _____

Title _____

Address _____

City, State, Zip _____

Phone

Fax

Email

Date

AZ LEAGUE CONNECTION



The League's Monthly Online Newsletter

Issue 192: April 2019

League News

[2019 League Annual Conference \(league-annual-conference.html\)](#)

[League Conference Sponsorship \(league-corporate-sponsorship.html\)](#)

[Service Award List \(league-service-awards.html\)](#)

[Municipal Clerks Week: May 5 – 11, 2019 \(municipal-clerks-week.html\)](#)

[League Publications \(league-publications.html\)](#)

[Arizona City and Town Hall \(city-town.html\)](#)

[Municipal Grants Training \(league-training.html\)](#)

Other News

[Six Ways to Connect Across Divides \(6-ways-connect-across-divides.html\)](#)

[HUD Announces Request for Information on](#)



Legal Corner: Video Services Update

In 2018, the Legislature enacted uniform video service license legislation that requires cities and towns to adopt a standard uniform video service license agreement and application for the uniform license by July 1, 2019. This article provides a review of those provisions of the legislation and an update on the form templates that can be used by cities and towns.

[Senate Bill 1140](#)

[\(https://www.azleg.gov/legtext/53leg/2R/laws/0331.htm\)](https://www.azleg.gov/legtext/53leg/2R/laws/0331.htm) (Laws 2018, Ch. 331) preempts city and town regulation of the licensing of video service providers and the use of video service. The legislation mandated that cities and towns issue uniform video service licenses to video service providers beginning July 1, 2019. Municipalities are required to adopt a standard license agreement and a standard form of application and affidavit signed by one of the principal executive officers or general partners of the applicant. A video service provider

[Maximizing the Positive Impact of Opportunity Zones \(affordable-housing.html\)](#)

Legal Corner

[Video Services Update \(legal-corner.html\)](#)

Upcoming Trainings & Events

[2019 ACAA Summer Conference \(training-events.html#event-1\)](#)
[Trends in Affordable and Workforce Housing: Adapting Best Practices to Arizona \(training-events.html#event-2\)](#)
[Arizona Women Leading Government Conference \(training-events.html#event-3\)](#)
[ACMA Summer Conference \(training-events.html#event-4\)](#)

Throwback

[51 Years Ago \(throwback.html#throwback1\)](#)
[143 Years Ago \(throwback.html#throwback2\)](#)



Calendar of Events

[\(http://www.azleague.org/calendar.aspx\)](http://www.azleague.org/calendar.aspx)



means any person that provides or offers to provide video service over a video service network to subscribers in Arizona and includes incumbent cable operators (those already providing video service in Arizona through a local license on December 31, 2019 who choose to terminate the local license). [A.R.S. § 9-1401 \(https://www.azleg.gov/viewdocument/?docName=https://www.azleg.gov/ars/9/01401.htm\)](https://www.azleg.gov/viewdocument/?docName=https://www.azleg.gov/ars/9/01401.htm).

Incumbent Cable Operators and Holdover Cable Operators

From January 1, 2020 until June 30, 2020, incumbent cable operators may elect to continue to operate pursuant to the local license or terminate the local license and apply for a uniform video service license. If the incumbent cable operator obtains a uniform video service license, the local license is terminated when the uniform license is issued and the operator operates within the service area defined in the local license. [A.R.S. § 9-1412 \(https://www.azleg.gov/viewdocument/?docName=https://www.azleg.gov/ars/9/01412.htm\)](https://www.azleg.gov/viewdocument/?docName=https://www.azleg.gov/ars/9/01412.htm). If the operator does not timely elect to terminate a local license, the person continues to operate the cable system as a holdover cable operator pursuant to the local license. [A.R.S. § 9-1413 \(https://www.azleg.gov/viewdocument/?docName=https://www.azleg.gov/ars/9/01413.htm\)](https://www.azleg.gov/viewdocument/?docName=https://www.azleg.gov/ars/9/01413.htm). Following the natural termination of the local license, the holdover cable operator must apply for a uniform video service license at least one month prior to the expiration of the local license.

Application and Affidavit Requirements

The legislation requires the application and affidavit to include the service area, the uniform license agreement provisions, the term of the license, and an agreement to pay any fees and charges. The application and affidavit must be filed with the municipal clerk and must contain the service area where the applicant intends to provide video service, contact information and the date when service will begin (if not an incumbent provider), the term of the license, and an agreement to pay all

Municipal Employment Opportunities

(<http://www.azleague.org/jobs.aspx>)



(<http://azcitieswork.com/>)

lawful fees and charges imposed by the municipality. It is important for your clerk to know the appropriate individual in your city or town who processes the application and affidavit since the city or town has only fifteen business days to make an initial determination and reject the application and affidavit if incomplete or otherwise deficient (by written notice). A.R.S. § 9-1414 (<https://www.azleg.gov/viewdocument/?docName=https://www.azleg.gov/ars/9/01414.htm>).

Uniform Video Service License Agreement

The uniform video services license agreement contains sixteen separate provisions including the date on which the provider expects to provide video services in the area, a description of the service area to be served, a requirement that the provider will pay the license fees and all other lawful charges imposed by cities and towns, and requirements that the provider comply with federal, state and local laws, consumer privacy mandates and public, education and government programming requirements. A.R.S § 9-1411 (<https://www.azleg.gov/viewdocument/?docName=https://www.azleg.gov/ars/9/01411.htm>). The city or town must issue the uniform license to the applicant thirty days after the filing of a completed application and affidavit. A.R.S § 9-1415 (<https://www.azleg.gov/viewdocument/?docName=https://www.azleg.gov/ars/9/01415.htm>).

Conclusion

This article focused on the initial licensing process and the required forms each city and town must utilize to implement the uniform video services legislation. For more information on other provisions of the legislation relating to right-of-way management, appeals process, termination or transfer of licenses, and fee limitations, please see the 2018 League New Laws summary.

<http://www.azleague.org/ArchiveCenter/ViewFile/Item/338>

(page 14) or [SB1140](#)

<https://www.azleg.gov/legtext/53leg/2R/laws/0331.htm>).

The Telecommunications Workgroup has drafted a model video services license agreement and application and affidavit with the assistance of stakeholders and the cable industry. These forms were distributed to all municipal attorneys last week and are available here:

[Video Services Application and Affidavit](#)

<http://azleague.org/DocumentCenter/View/10922>

[Video Services License Agreement](#)

<http://www.azleague.org/documentcenter/view/10921>

azleague.org

<http://www.azleague.org>

Follow us: 

<https://www.facebook.com/AZCities/>



<https://twitter.com/azcities>



https://www.youtube.com/channel/UCJSFxFYlrzLo6_YPRT4E1wMQ



<https://www.instagram.com/azcities/>

League of Arizona Cities

and Towns

1820 W Washington Street

Phoenix, AZ 85007

Phone: 602-258-5786

Fax: 602-253-3874

Email:

newsletter@azleague.org

<mailto:newsletter@azleague.org>



Introduction

Welcome to the *2018 New Laws Report of the League of Arizona Cities and Towns*. The Report is designed to serve as a guide to those enactments of the second regular session of the 53rd Arizona Legislature that have demonstrable impacts on municipalities.

During the past session, 1,206 bills were introduced in the House and Senate. Of these, 370 passed the legislature (369 in Regular Session and one enacted in a Special Session) and were sent to the Governor, and 346 were signed into law. Almost 23% of these enactments affect cities and towns and are summarized in the Report.

Scope and Use

This Report is intended only to identify and summarize those new laws with significant impacts on Arizona municipalities. It does not describe every provision of every law in detail, but it does provide a hyperlink to the chaptered version of each law summarized. To gain a better understanding of the new laws, readers are encouraged to review the exact language of their provisions as well as relevant legislative history. For those new enactments that modify current law, the Report makes no effort to describe the underlying law other than to provide sufficient context for an understanding of the statutory modification. Furthermore, the Report focuses on only those new laws that have broad statewide applicability to cities and towns.

Effective Dates

Unless otherwise noted, the effective date of the new laws described in the Report is August 3, 2018. This date – 90 days after the conclusion of the legislative session – is the general effective date for all enactments that are passed without an emergency clause or alternative effective date. The Report does endeavor to identify effective dates that vary from the general effective date. Where appropriate, it also includes other statutory dates, such as repeal dates, implementation dates and deadlines.

Disclaimers

The Report, published as a service to the members of the League of Arizona Cities and Towns, does not necessarily identify every law with impacts on municipalities. It is neither designed nor intended to provide legal advice or counsel. It should be relied upon only as a reference tool and not as a comprehensive guidance document. In certain limited instances, the Report does highlight action items that should be considered by cities and towns. In no case, however, should the Report substitute for the independent judgment of your city or town manager or attorney.

Part Four

General Government

SB 1042 (backflow prevention; state fire code)

([Chapter 19](#))

Requires backflow prevention equipment on class 1 or class 2 fire protection systems to be approved, inspected and maintained in accordance with the state fire code, instead of a National Fire Protection Association publication or the uniform fire code.

SB 1111 (workers' compensation; opioids; dispensed medications)

([Chapter 101](#))

Requires a physician that prescribes a narcotic or opium-based controlled substance listed in Schedule II or a prescription of any opioid medication that is given to an employee to include in the report to the Industrial Commission documentation that a physical examination of the employee was conducted, that a substance use risk assessment of the employee was completed and that the employee gave informed consent for any opioid treatment. Requires the treatment plan for these medications to include face-to-face follow up visits to reevaluate the employee's continued use of opioids, criteria and procedures for tapering and discontinuing opioid prescription or administration and criteria and procedures for offering or referring the employee for treatment for dependence on or addiction to opioids. Requires the physician to obtain a patient utilization report regarding the employee from the controlled substances prescription monitoring program's central database tracking system before prescribing an opioid analgesic or benzodiazepine controlled substance that is listed in schedule II, III or IV and at least quarterly while that prescription remains a part of the treatment. Requires the Industrial Commission to review information and data, consult with stakeholders and hold at least one public hearing by July 1, 2019 in considering whether to adopt additional reimbursement guidelines for medications dispensed in settings that are not accessible to the general public.

SB 1140 (certificates of authority; video service)

([Chapter 331](#))

Establishes a uniform video service license, issued by cities, towns and counties, and allows cable companies to terminate existing cable franchise license agreements for the uniform license after January 1, 2020. Requires cities and towns to adopt a standard uniform video service license agreement and application for the uniform license by July 1, 2019. Prohibits local regulation of video service providers or their networks beyond requirements related to license issuance and right-of-way management; build-out, line extension or other requirements related to infrastructure, facilities and deployment of equipment are also prohibited. Requires the Office of Administrative Hearings to oversee license-related disputes, including disputes regarding under or overpayment of license fees. Specifies requirements for license fee audits and allocation of bundling discounts and requirements for video service providers to add or terminate service territories and extend or transfer a video service license. PEG channel capacity is limited to four - two channels in the basic tier and two channels in the digital tier; or two lines of programming in standard definition and two in switched digital. Cities and towns are prohibited from charging a filing or processing fee for and from taking any official action on the application to receive a video service license.



Introduction

Welcome to the *2018 New Laws Report of the League of Arizona Cities and Towns*. The Report is designed to serve as a guide to those enactments of the second regular session of the 53rd Arizona Legislature that have demonstrable impacts on municipalities.

During the past session, 1,206 bills were introduced in the House and Senate. Of these, 370 passed the legislature (369 in Regular Session and one enacted in a Special Session) and were sent to the Governor, and 346 were signed into law. Almost 23% of these enactments affect cities and towns and are summarized in the Report.

Scope and Use

This Report is intended only to identify and summarize those new laws with significant impacts on Arizona municipalities. It does not describe every provision of every law in detail, but it does provide a hyperlink to the chaptered version of each law summarized. To gain a better understanding of the new laws, readers are encouraged to review the exact language of their provisions as well as relevant legislative history. For those new enactments that modify current law, the Report makes no effort to describe the underlying law other than to provide sufficient context for an understanding of the statutory modification. Furthermore, the Report focuses on only those new laws that have broad statewide applicability to cities and towns.

Effective Dates

Unless otherwise noted, the effective date of the new laws described in the Report is August 3, 2018. This date – 90 days after the conclusion of the legislative session – is the general effective date for all enactments that are passed without an emergency clause or alternative effective date. The Report does endeavor to identify effective dates that vary from the general effective date. Where appropriate, it also includes other statutory dates, such as repeal dates, implementation dates and deadlines.

Disclaimers

The Report, published as a service to the members of the League of Arizona Cities and Towns, does not necessarily identify every law with impacts on municipalities. It is neither designed nor intended to provide legal advice or counsel. It should be relied upon only as a reference tool and not as a comprehensive guidance document. In certain limited instances, the Report does highlight action items that should be considered by cities and towns. In no case, however, should the Report substitute for the independent judgment of your city or town manager or attorney.

Part Four

General Government

SB 1042 (backflow prevention; state fire code)

([Chapter 19](#))

Requires backflow prevention equipment on class 1 or class 2 fire protection systems to be approved, inspected and maintained in accordance with the state fire code, instead of a National Fire Protection Association publication or the uniform fire code.

SB 1111 (workers' compensation; opioids; dispensed medications)

([Chapter 101](#))

Requires a physician that prescribes a narcotic or opium-based controlled substance listed in Schedule II or a prescription of any opioid medication that is given to an employee to include in the report to the Industrial Commission documentation that a physical examination of the employee was conducted, that a substance use risk assessment of the employee was completed and that the employee gave informed consent for any opioid treatment. Requires the treatment plan for these medications to include face-to-face follow up visits to reevaluate the employee's continued use of opioids, criteria and procedures for tapering and discontinuing opioid prescription or administration and criteria and procedures for offering or referring the employee for treatment for dependence on or addiction to opioids. Requires the physician to obtain a patient utilization report regarding the employee from the controlled substances prescription monitoring program's central database tracking system before prescribing an opioid analgesic or benzodiazepine controlled substance that is listed in schedule II, III or IV and at least quarterly while that prescription remains a part of the treatment. Requires the Industrial Commission to review information and data, consult with stakeholders and hold at least one public hearing by July 1, 2019 in considering whether to adopt additional reimbursement guidelines for medications dispensed in settings that are not accessible to the general public.

SB 1140 (certificates of authority; video service)

([Chapter 331](#))

Establishes a uniform video service license, issued by cities, towns and counties, and allows cable companies to terminate existing cable franchise license agreements for the uniform license after January 1, 2020. Requires cities and towns to adopt a standard uniform video service license agreement and application for the uniform license by July 1, 2019. Prohibits local regulation of video service providers or their networks beyond requirements related to license issuance and right-of-way management; build-out, line extension or other requirements related to infrastructure, facilities and deployment of equipment are also prohibited. Requires the Office of Administrative Hearings to oversee license-related disputes, including disputes regarding under or overpayment of license fees. Specifies requirements for license fee audits and allocation of bundling discounts and requirements for video service providers to add or terminate service territories and extend or transfer a video service license. PEG channel capacity is limited to four - two channels in the basic tier and two channels in the digital tier; or two lines of programming in standard definition and two in switched digital. Cities and towns are prohibited from charging a filing or processing fee for and from taking any official action on the application to receive a video service license.

State of Arizona
Senate
Fifty-third Legislature
Second Regular Session
2018

CHAPTER 331
SENATE BILL 1140

AN ACT

AMENDING TITLE 9, ARIZONA REVISED STATUTES, BY ADDING CHAPTER 13; AMENDING SECTION 41-1092.01, ARIZONA REVISED STATUTES; RELATING TO VIDEO AND CABLE SERVICE PROVIDERS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Title 9, Arizona Revised Statutes, is amended by adding
3 chapter 13, to read:

4 CHAPTER 13

5 VIDEO SERVICE

6 ARTICLE 1. GENERAL PROVISIONS

7 9-1401. Definitions

8 IN THIS CHAPTER, UNLESS THE CONTEXT OTHERWISE REQUIRES:

9 1. "AFFILIATE" MEANS A PERSON THAT DIRECTLY OR INDIRECTLY, THROUGH
10 ONE OR MORE INTERMEDIARIES, CONTROLS, IS CONTROLLED BY OR IS UNDER COMMON
11 CONTROL WITH A VIDEO SERVICE PROVIDER.

12 2. "AGREEMENT" MEANS ANY AGREEMENT OR CONTRACT.

13 3. "BOUNDARIES OF A LOCAL GOVERNMENT" OR "BOUNDARIES" MEANS:

14 (a) FOR A CITY OR TOWN, ALL OF THE AREA WITHIN THE CORPORATE LIMITS
15 OF THE CITY OR TOWN.

16 (b) FOR A COUNTY, ALL OF THE AREA OF THE COUNTY THAT IS NOT WITHIN
17 THE CORPORATE LIMITS OF ANY CITY OR TOWN, INCLUDING UNINCORPORATED
18 TERRITORY THAT IS SURROUNDED ON ALL SIDES BY A COMBINATION OF ONE OR MORE
19 CITIES, TOWNS OR INDIAN RESERVATIONS.

20 4. "CABLE OPERATOR" HAS THE SAME MEANING PRESCRIBED IN 47 UNITED
21 STATES CODE SECTION 522.

22 5. "CABLE SERVICE" HAS THE SAME MEANING PRESCRIBED IN 47 UNITED
23 STATES CODE SECTION 522.

24 6. "CABLE SYSTEM" HAS THE SAME MEANING PRESCRIBED IN 47 UNITED
25 STATES CODE SECTION 522.

26 7. "COMMERCIAL MOBILE SERVICE PROVIDER" MEANS A PERSON THAT
27 PROVIDES COMMERCIAL MOBILE SERVICE AS DEFINED IN 47 UNITED STATES CODE
28 SECTION 332(d) OR COMMERCIAL MOBILE RADIO SERVICE AS DESCRIBED IN 47 CODE
29 OF FEDERAL REGULATIONS SECTION 20.9.

30 8. "DAY" MEANS A CALENDAR DAY, EXCEPT A SATURDAY OR SUNDAY OR A
31 HOLIDAY PRESCRIBED IN SECTION 1-301.

32 9. "GROSS REVENUE":

33 (a) MEANS ALL CASH, CREDITS, PROPERTY OF ANY KIND OR NATURE OR
34 OTHER CONSIDERATION THAT IS RECEIVED DIRECTLY OR INDIRECTLY BY A VIDEO
35 SERVICE PROVIDER, ITS AFFILIATES, OR ANY PERSON, FIRM OR CORPORATION IN
36 WHICH THE VIDEO SERVICE PROVIDER HAS A FINANCIAL INTEREST OR THAT HAS A
37 FINANCIAL INTEREST IN THE VIDEO SERVICE PROVIDER AND THAT IS DERIVED FROM
38 THE VIDEO SERVICE PROVIDER'S OPERATION OF ITS VIDEO SERVICE NETWORK TO
39 PROVIDE VIDEO SERVICE IN THE SERVICE AREA.

40 (b) INCLUDES ALL REVENUE FROM CHARGES FOR VIDEO SERVICE TO
41 SUBSCRIBERS AND ALL CHARGES FOR INSTALLATION, REMOVAL, CONNECTION OR
42 REINSTATEMENT OF EQUIPMENT NECESSARY FOR A SUBSCRIBER TO RECEIVE VIDEO
43 SERVICE AND ANY OTHER RECEIPTS FROM SUBSCRIBERS DERIVED FROM THE VIDEO
44 SERVICE PROVIDER'S OPERATION OF THE VIDEO SERVICE NETWORK TO PROVIDE VIDEO
45 SERVICE, INCLUDING RECEIPTS FROM FORFEITED DEPOSITS, SALE OR RENTAL OF

1 EQUIPMENT TO PROVIDE VIDEO SERVICE, LATE CHARGES, INTEREST AND SALE OF
2 PROGRAM GUIDES.

3 (c) DOES NOT INCLUDE:

4 (i) ANY REVENUE NOT RECEIVED, EVEN IF BILLED, SUCH AS BAD DEBT NET
5 OF ANY RECOVERIES OF BAD DEBT OR ANY REFUNDS, CREDITS, ALLOWANCES OR
6 DISCOUNTS TO SUBSCRIBERS TO THE EXTENT THAT THE REFUND, REBATE, CREDIT,
7 ALLOWANCE OR DISCOUNT IS ATTRIBUTED TO VIDEO SERVICE.

8 (ii) REVENUE FROM COMMERCIAL ADVERTISING ON THE VIDEO SERVICE
9 NETWORK, THE USE OR LEASE OF STUDIO FACILITIES OF THE VIDEO SERVICE
10 NETWORK, INTERNET ACCESS SERVICE, THE USE OR LEASE OF ITS FACILITIES
11 LOCATED IN THE HIGHWAYS, THE USE OR LEASE OF LEASED ACCESS CHANNELS OR
12 BANDWIDTH, THE USE OR LEASE OF TOWERS, THE PRODUCTION OF VIDEO PROGRAMMING
13 BY THE VIDEO SERVICE PROVIDER, THE SALE, EXCHANGE, USE OR CABLECAST OF ANY
14 PROGRAMMING BY THE VIDEO SERVICE PROVIDER IN THE SERVICE AREA, SALES TO
15 THE VIDEO SERVICE PROVIDER'S SUBSCRIBERS BY PROGRAMMERS OF HOME SHOPPING
16 SERVICES, REIMBURSEMENTS PAID BY PROGRAMMERS FOR LAUNCH FEES OR MARKETING
17 EXPENSES, LICENSE FEES, TAXES OR OTHER FEES OR CHARGES THAT THE VIDEO
18 SERVICE PROVIDER COLLECTS AND PAYS TO ANY GOVERNMENTAL AUTHORITY, ANY
19 INCREASE IN THE VALUE OF ANY STOCK, SECURITY OR ASSET, OR ANY DIVIDENDS OR
20 OTHER DISTRIBUTIONS MADE FROM ANY STOCK OR SECURITIES.

21 10. "HIGHWAY" MEANS ALL ROADS, STREETS AND ALLEYS AND OTHER
22 DEDICATED PUBLIC RIGHTS-OF-WAY THAT ARE OPERATED AND MAINTAINED BY A LOCAL
23 GOVERNMENT.

24 11. "HOLDER" MEANS A VIDEO SERVICE PROVIDER THAT HAS BEEN ISSUED A
25 UNIFORM VIDEO SERVICE LICENSE PURSUANT TO THIS CHAPTER.

26 12. "HOLDOVER CABLE OPERATOR" MEANS AN INCUMBENT CABLE OPERATOR
27 THAT ELECTS UNDER SECTIONS 9-1412 AND 9-1413 TO CONTINUE TO OPERATE WITHIN
28 ITS SERVICE AREA PURSUANT TO ITS LOCAL LICENSE.

29 13. "INCUMBENT CABLE OPERATOR" MEANS A CABLE OPERATOR OR OTHER
30 VIDEO SERVICE PROVIDER THAT ON DECEMBER 31, 2019 IS PROVIDING VIDEO
31 SERVICE IN THIS STATE PURSUANT TO A LOCAL LICENSE.

32 14. "INFORMATION SERVICE" HAS THE SAME MEANING PRESCRIBED IN 47
33 UNITED STATES CODE SECTION 153.

34 15. "INTERACTIVE COMPUTER SERVICE" HAS THE SAME MEANING PRESCRIBED
35 IN 47 UNITED STATES CODE SECTION 230(f).

36 16. "LICENSE" MEANS A FRANCHISE AS DEFINED IN 47 UNITED STATES CODE
37 SECTION 522.

38 17. "LICENSE FEE" MEANS A LICENSE FEE IMPOSED BY A LOCAL GOVERNMENT
39 ON A VIDEO SERVICE PROVIDER FOR USING THE HIGHWAYS TO PROVIDE AND FOR THE
40 PRIVILEGE OF PROVIDING VIDEO SERVICE.

41 18. "LOCAL GOVERNMENT" MEANS ANY CITY, INCLUDING A CHARTER CITY,
42 TOWN OR COUNTY.

43 19. "LOCAL LAW" MEANS ANY CHARTER, CODE, ORDINANCE, RESOLUTION,
44 REGULATION OR OTHER LAW OF A LOCAL GOVERNMENT.

1 20. "LOCAL LICENSE" MEANS ANY LICENSE, AGREEMENT, PERMIT OR SIMILAR
2 AUTHORIZATION THAT MEETS ALL OF THE FOLLOWING:

3 (a) ALLOWS A PERSON TO CONSTRUCT OR OPERATE A VIDEO SERVICE NETWORK
4 WITHIN THE BOUNDARIES OF A LOCAL GOVERNMENT.

5 (b) IS ISSUED, GRANTED, APPROVED, EXTENDED OR RENEWED BY THE LOCAL
6 GOVERNMENT BEFORE JANUARY 1, 2020 PURSUANT TO THE AUTHORITY OF ANY
7 FEDERAL, STATE OR LOCAL LAW IN EFFECT AT THE TIME OF THE ISSUANCE, GRANT,
8 APPROVAL, EXTENSION OR RENEWAL.

9 (c) IS EFFECTIVE UNDER FEDERAL, STATE OR LOCAL LAW ON DECEMBER 31,
10 2019 FOR THE PERSON TO CONTINUE TO CONSTRUCT OR OPERATE A VIDEO SERVICE
11 NETWORK WITHIN THE BOUNDARIES OF A LOCAL GOVERNMENT.

12 21. "MULTICHANNEL VIDEO PROGRAMMING DISTRIBUTOR" HAS THE SAME
13 MEANING PRESCRIBED IN 47 UNITED STATES CODE SECTION 522.

14 22. "SERVICE AREA" MEANS THAT PART OF THE BOUNDARIES OF A LOCAL
15 GOVERNMENT WITHIN WHICH A VIDEO SERVICE PROVIDER IS AUTHORIZED TO PROVIDE
16 VIDEO SERVICE PURSUANT TO A UNIFORM VIDEO SERVICE LICENSE OR A LOCAL
17 LICENSE.

18 23. "SUBSCRIBER" MEANS ANY PERSON IN THIS STATE THAT PURCHASES
19 VIDEO SERVICE. SUBSCRIBER DOES NOT INCLUDE ANY PERSON THAT PURCHASES
20 VIDEO SERVICE FOR RESALE AND THAT, ON RESALE, IS REQUIRED TO PAY A LICENSE
21 FEE PURSUANT TO THIS CHAPTER OR THE TERMS OF A LOCAL LICENSE.

22 24. "TELECOMMUNICATIONS":

23 (a) MEANS THE TRANSMISSION, BETWEEN OR AMONG POINTS SPECIFIED BY
24 THE USER, OF INFORMATION OF THE USER'S CHOOSING, WITHOUT CHANGE IN THE
25 FORM OR CONTENT OF THE INFORMATION SENT AND RECEIVED, REGARDLESS OF THE
26 FACILITIES, EQUIPMENT OR TECHNOLOGY USED.

27 (b) DOES NOT INCLUDE COMMERCIAL MOBILE RADIO SERVICE, PAY PHONE
28 SERVICE, INTERSTATE SERVICE OR CABLE SERVICE.

29 25. "TELECOMMUNICATIONS PROVIDER" MEANS A PERSON THAT IS REQUIRED
30 TO OBTAIN FROM THE CORPORATION COMMISSION A CERTIFICATE OF PUBLIC
31 CONVENIENCE AND NECESSITY TO PROVIDE TELECOMMUNICATIONS SERVICE.

32 26. "TELECOMMUNICATIONS SERVICE" MEANS THE OFFERING OF
33 TELECOMMUNICATIONS FOR A FEE DIRECTLY TO THE PUBLIC, OR TO SUCH USERS AS
34 TO BE EFFECTIVELY AVAILABLE DIRECTLY TO THE PUBLIC, REGARDLESS OF THE
35 EQUIPMENT, FACILITIES OR TECHNOLOGY USED.

36 27. "UNIFORM VIDEO SERVICE LICENSE" MEANS A LICENSE THAT IS ISSUED
37 BY A LOCAL GOVERNMENT IN THE FORM OF A UNIFORM VIDEO SERVICE LICENSE
38 AGREEMENT AS ADOPTED PURSUANT TO SECTION 9-1411.

39 28. "VIDEO SERVICE":

40 (a) MEANS THE PROVISION OF MULTICHANNEL VIDEO PROGRAMMING GENERALLY
41 CONSIDERED COMPARABLE TO VIDEO PROGRAMMING DELIVERED BY A TELEVISION
42 BROADCAST STATION, VIDEO SERVICE OR OTHER DIGITAL TELEVISION SERVICE,
43 WHETHER PROVIDED AS PART OF A TIER, ON DEMAND OR ON A PER-CHANNEL BASIS,
44 WITHOUT REGARD TO THE TECHNOLOGY USED TO DELIVER THE VIDEO SERVICE,
45 INCLUDING INTERNET PROTOCOL TECHNOLOGY OR ANY SUCCESSOR TECHNOLOGY.

1 (b) INCLUDES CABLE SERVICE.

2 (c) DOES NOT INCLUDE ANY OF THE FOLLOWING:

3 (i) VIDEO PROGRAMMING PROVIDED SOLELY AS PART OF, AND THROUGH, A
4 SERVICE THAT ENABLES USERS TO ACCESS CONTENT, INFORMATION, E-MAIL,
5 MESSAGING OR OTHER SERVICES THAT ARE OFFERED VIA THE PUBLIC INTERNET.

6 (ii) DIRECT BROADCAST SATELLITE SERVICE.

7 (iii) WIRELESS MULTICHANNEL VIDEO PROGRAMMING THAT IS PROVIDED BY A
8 COMMERCIAL MOBILE SERVICE PROVIDER.

9 29. "VIDEO SERVICE NETWORK":

10 (a) MEANS A WIRELINE NETWORK, OR ANY COMPONENT OF A WIRELINE
11 NETWORK, THAT IS LOCATED IN THIS STATE, CONSTRUCTED IN WHOLE OR IN PART
12 IN, ON, UNDER OR OVER ANY HIGHWAY AND USED TO PROVIDE VIDEO SERVICE.

13 (b) INCLUDES A CABLE SYSTEM.

14 30. "VIDEO SERVICE PROVIDER":

15 (a) MEANS ANY PERSON THAT PROVIDES OR OFFERS TO PROVIDE VIDEO
16 SERVICE OVER A VIDEO SERVICE NETWORK TO SUBSCRIBERS IN THIS STATE.

17 (b) INCLUDES AN INCUMBENT CABLE OPERATOR THAT ELECTED PURSUANT TO
18 SECTIONS 9-1412 AND 9-1413 TO TERMINATE ITS LOCAL LICENSE AND A
19 MULTICHANNEL VIDEO PROGRAMMING DISTRIBUTOR.

20 (c) DOES NOT INCLUDE A HOLDOVER CABLE OPERATOR.

21 9-1402. State preemption; uniform regulation and licensing

22 A. THE LICENSING OF VIDEO SERVICE PROVIDERS AND THE REGULATION AND
23 USE OF VIDEO SERVICE ARE MATTERS OF STATEWIDE CONCERN. EXCEPT AS PROVIDED
24 IN THIS CHAPTER, THE LICENSING OF VIDEO SERVICE PROVIDERS AND THE
25 REGULATION AND USE OF VIDEO SERVICE ARE NOT SUBJECT TO FURTHER REGULATION
26 BY A LOCAL GOVERNMENT. THE REGULATION OF VIDEO SERVICE PURSUANT TO THIS
27 CHAPTER, INCLUDING APPLICATION TO THE LOCAL LICENSES OF INCUMBENT CABLE
28 OPERATORS, IS REASONABLE AND NECESSARY TO PROMOTE ALL OF THE FOLLOWING:

29 1. PROVISION OF COMPETITIVE VIDEO, TELECOMMUNICATIONS AND
30 INFORMATION SERVICE THROUGHOUT THIS STATE.

31 2. MORE UNIFORM REGULATION OF COMPETITIVE VIDEO SERVICE THROUGHOUT
32 THIS STATE.

33 3. STREAMLINED LICENSING BY LOCAL GOVERNMENTS AND MORE UNIFORM
34 TERMS AND CONDITIONS FOR VIDEO SERVICE PROVIDERS THAT USE HIGHWAYS TO
35 PROVIDE VIDEO AND OTHER SERVICES OVER VIDEO SERVICE NETWORKS.

36 4. CONTINUED MANAGEMENT BY LOCAL GOVERNMENTS OF USE OF THEIR
37 HIGHWAYS WITH REASONABLE BURDENS ON CONSTRUCTION AND MAINTENANCE ACROSS
38 BOUNDARIES BETWEEN LOCAL GOVERNMENTS FOR VIDEO SERVICE PROVIDERS TO USE
39 HIGHWAYS TO PROVIDE VIDEO AND OTHER SERVICES OVER VIDEO SERVICE NETWORKS.

40 5. CONTINUED LEVYING OF LICENSE FEES BY LOCAL GOVERNMENTS ON
41 SUBSCRIBER SERVICE REVENUES DERIVED FROM OPERATING VIDEO SERVICE NETWORKS
42 TO PROVIDE VIDEO SERVICE.

43 6. SUPPORT FOR FEDERAL SUBSCRIBER SERVICE STANDARDS.

44 B. TO THE FULLEST EXTENT ALLOWED BY FEDERAL LAW, THIS CHAPTER
45 OCCUPIES THE ENTIRE FIELD OF LICENSING AND REGULATION OF VIDEO SERVICE.

1 C. EXCEPT AS OTHERWISE PROVIDED IN THIS CHAPTER, FROM AND AFTER
2 DECEMBER 31, 2019 THIS CHAPTER PREEMPTS AND LIMITS THE ABILITY OF A LOCAL
3 GOVERNMENT TO REGULATE OR ENFORCE ALL OF THE FOLLOWING:

4 1. THE APPLICATION OF CHAPTER 5, ARTICLE 1.1 OF THIS TITLE TO VIDEO
5 SERVICE PROVIDERS.

6 2. ANY LOCAL LAW AND ANY AGREEMENT WITH A LOCAL GOVERNMENT THAT
7 DOES ANY OF THE FOLLOWING:

8 (a) REQUIRES A PERSON OTHER THAN A HOLDOVER CABLE OPERATOR TO
9 OBTAIN OR HOLD FROM A LOCAL GOVERNMENT ANY LICENSE, PERMIT OR SIMILAR
10 AUTHORIZATION THAT IS A PREREQUISITE TO PROVIDING VIDEO SERVICE OR TO
11 CONSTRUCTING, MAINTAINING OR USING THE HIGHWAYS TO OPERATE A VIDEO SERVICE
12 NETWORK IN THE HIGHWAYS WITHIN ITS BOUNDARIES.

13 (b) REGULATES THE PROVISION OF VIDEO SERVICE OR THE CONSTRUCTION OR
14 OPERATION OF A VIDEO SERVICE NETWORK IF THE LOCAL LAW DOES NOT CONFORM TO
15 THIS CHAPTER.

16 (c) IMPOSES ON A VIDEO SERVICE PROVIDER ANY REQUIREMENT THAT IS
17 RELATED TO INFRASTRUCTURE, FACILITIES OR DEPLOYMENT OF EQUIPMENT THAT DOES
18 NOT CONFORM TO THIS CHAPTER, INCLUDING OFFICE LOCATION, INSTITUTIONAL
19 NETWORK, BUILD-OUT, LINE EXTENSION, INVESTMENT OR OTHER OPERATIONAL
20 REQUIREMENTS THAT ARE NOT DIRECTLY RELATED TO THE LOCAL GOVERNMENT'S
21 MANAGEMENT OF THE HIGHWAYS.

22 (d) REQUIRES A VIDEO SERVICE PROVIDER TO OBTAIN A LICENSE OR OTHER
23 AUTHORIZATION FROM THE LOCAL GOVERNMENT TO PROVIDE TELECOMMUNICATIONS
24 SERVICE, INFORMATION SERVICE, INTERACTIVE COMPUTER SERVICE OR OTHER
25 SERVICE IF THE VIDEO SERVICE PROVIDER USES ITS VIDEO SERVICE NETWORK
26 WITHIN THE BOUNDARIES OF THE LOCAL GOVERNMENT TO PROVIDE THE SERVICE.

27 (e) REQUIRES A VIDEO SERVICE PROVIDER TO PAY TO LOCATE IN DUCTS OR
28 CONDUITS OR ON POLES OWNED BY THE LOCAL GOVERNMENT IF THE LOCAL GOVERNMENT
29 REQUIRES INSTALLATION IN THE DUCTS OR CONDUITS OR ON THE POLES.

30 9-1403. Limited application

31 THIS CHAPTER DOES NOT:

32 1. PREVENT A TELECOMMUNICATIONS PROVIDER FROM EXERCISING ANY RIGHTS
33 OR AUTHORITY THAT THE TELECOMMUNICATIONS PROVIDER HAS AS A PUBLIC UTILITY
34 UNDER FEDERAL OR STATE LAW.

35 2. AFFECT ANY AUTHORITY OF A LOCAL GOVERNMENT, AN AGRICULTURAL
36 IMPROVEMENT DISTRICT, ANY SPECIAL TAXING DISTRICT OR ANY OTHER PERSON THAT
37 CONTROLS UTILITY POLES ON THE HIGHWAYS TO DENY, LIMIT, RESTRICT OR
38 DETERMINE THE RATES, TERMS AND CONDITIONS FOR THE USE OF OR ATTACHMENT BY
39 A VIDEO SERVICE PROVIDER TO UTILITY OR OTHER POLES OWNED BY THE LOCAL
40 GOVERNMENT OR OTHER PERSON. FOR THE PURPOSES OF THIS PARAGRAPH,
41 "AUTHORITY OF A LOCAL GOVERNMENT" INCLUDES POLICE POWERS.

42 3. VEST IN THE CORPORATION COMMISSION ANY AUTHORITY OR JURISDICTION
43 OVER VIDEO SERVICE, VIDEO SERVICE PROVIDERS OR VIDEO SERVICE NETWORKS OR
44 OVER THE RATES, TERMS AND CONDITIONS OF POLE ATTACHMENTS UNDER 47 UNITED
45 STATES CODE SECTION 224.

1 4. AFFECT OR PREEMPT ANY GENERALLY APPLICABLE LOCAL LAWS, INCLUDING
2 A LOCAL GOVERNMENT'S POLICE POWER, TO MANAGE THE USE AND OCCUPANCY OF THE
3 HIGHWAYS WITHIN THE LOCAL GOVERNMENT'S BOUNDARIES OR TO EXERCISE THE LOCAL
4 GOVERNMENT'S POLICE POWERS IF THE LOCAL GOVERNMENT APPLIES THE LOCAL LAWS
5 AND THE EXERCISE OF POLICE POWERS TO ALL USERS OF THE HIGHWAYS IN A
6 NONDISCRIMINATORY MANNER.

7 ARTICLE 2. LOCAL LICENSES

8 9-1411. Local governments; uniform video service license
9 agreements; forms; provisions

10 A. FROM AND AFTER DECEMBER 31, 2019, A LOCAL GOVERNMENT HAS THE
11 EXCLUSIVE AUTHORITY TO ISSUE A UNIFORM VIDEO SERVICE LICENSE TO A PERSON
12 TO PROVIDE VIDEO SERVICE AND TO CONSTRUCT AND OPERATE A VIDEO SERVICE
13 NETWORK IN ANY SERVICE AREA WITHIN ITS BOUNDARIES.

14 B. ON OR BEFORE JULY 1, 2019, EACH LOCAL GOVERNMENT SHALL ADOPT A
15 STANDARD FORM OF UNIFORM VIDEO SERVICE LICENSE AGREEMENT FOR VIDEO SERVICE
16 PROVIDERS TO BE USED BY THE LOCAL GOVERNMENT AND A STANDARD FORM OF
17 APPLICATION AND AFFIDAVIT AS DESCRIBED IN SECTION 9-1414. A LOCAL
18 GOVERNMENT SHALL PRESCRIBE OTHER FORMS ONLY AS NECESSARY TO IMPLEMENT THIS
19 CHAPTER.

20 C. THE UNIFORM VIDEO SERVICE LICENSE AGREEMENT ADOPTED UNDER
21 SUBSECTION B OF THIS SECTION MUST INCLUDE ALL OF THE FOLLOWING PROVISIONS
22 IN SUBSTANTIALLY THE FOLLOWING FORM AND MAY NOT INCLUDE ANY OTHER
23 PROVISIONS:

24 1. THE NAME OF THE VIDEO SERVICE PROVIDER, ITS TYPE OF ENTITY AND
25 ITS JURISDICTION OF FORMATION.

26 2. THE ADDRESS AND TELEPHONE NUMBER OF THE VIDEO SERVICE PROVIDER'S
27 PRINCIPAL PLACE OF BUSINESS.

28 3. THE NAME AND ADDRESS OF THE VIDEO SERVICE PROVIDER'S PRINCIPAL
29 EXECUTIVE OFFICERS OR GENERAL PARTNERS AND ANY PERSONS AUTHORIZED TO
30 REPRESENT THE VIDEO SERVICE PROVIDER BEFORE THE LOCAL GOVERNMENT.

31 4. IF THE VIDEO SERVICE PROVIDER IS NOT AN INCUMBENT CABLE
32 OPERATOR, THE DATE ON WHICH THE PROVIDER EXPECTS TO PROVIDE VIDEO SERVICES
33 IN THE AREA IDENTIFIED UNDER PARAGRAPH 5 OF THIS SUBSECTION.

34 5. AN EXACT DESCRIPTION OF THE SERVICE AREA TO BE SERVED, AS
35 IDENTIFIED BY A GEOGRAPHIC INFORMATION SYSTEM DIGITAL BOUNDARY THAT MEETS
36 OR EXCEEDS NATIONAL MAP ACCURACY STANDARDS.

37 6. A REQUIREMENT THAT THE VIDEO SERVICE PROVIDER PAY THE LICENSE
38 FEES REQUIRED UNDER THIS CHAPTER AND ALL OTHER LAWFUL FEES AND CHARGES
39 IMPOSED BY THE LOCAL GOVERNMENT.

40 7. A REQUIREMENT THAT THE VIDEO SERVICE PROVIDER FILE IN A TIMELY
41 MANNER WITH THE FEDERAL COMMUNICATIONS COMMISSION ALL FORMS REQUIRED BY
42 THAT AGENCY BEFORE OFFERING VIDEO SERVICE IN THE SERVICE AREA, INCLUDING
43 THE FORMS REQUIRED BY 47 CODE OF FEDERAL REGULATIONS SECTION 76.1801.

44 8. A REQUIREMENT THAT THE VIDEO SERVICE PROVIDER AGREES TO COMPLY
45 WITH AND BE SUBJECT TO ALL VALID AND ENFORCEABLE FEDERAL AND STATE LAWS.

1 9. A REQUIREMENT THAT THE VIDEO SERVICE PROVIDER AGREES TO COMPLY
2 WITH ALL GENERALLY APPLICABLE, NONDISCRIMINATORY LOCAL LAWS, INCLUDING
3 HIGHWAY USE, MAPPING, INSURANCE, PERFORMANCE BONDS, SECURITY FUND,
4 INDEMNIFICATION OR SIMILAR REQUIREMENTS THAT APPLY TO THE USE AND
5 OCCUPATION OF ANY HIGHWAY AND THAT CONFORM TO THIS CHAPTER.

6 10. A REQUIREMENT THAT THE VIDEO SERVICE PROVIDER COMPLY WITH THE
7 PUBLIC, EDUCATION AND GOVERNMENT PROGRAMMING REQUIREMENTS OF THIS CHAPTER.

8 11. A REQUIREMENT THAT THE VIDEO SERVICE PROVIDER COMPLY WITH ALL
9 CUSTOMER SERVICE RULES OF THE FEDERAL COMMUNICATIONS COMMISSION UNDER 47
10 CODE OF FEDERAL REGULATIONS SECTION 76.309(c) APPLICABLE TO CABLE
11 OPERATORS.

12 12. A REQUIREMENT THAT THE VIDEO SERVICE PROVIDER COMPLY WITH THE
13 CONSUMER PRIVACY REQUIREMENTS OF 47 UNITED STATES CODE SECTION 551
14 APPLICABLE TO CABLE OPERATORS.

15 13. A GRANT OF AUTHORITY BY THE LOCAL GOVERNMENT TO PROVIDE VIDEO
16 SERVICE IN THE SERVICE AREA AS DESCRIBED UNDER PARAGRAPH 5 OF THIS
17 SUBSECTION.

18 14. A GRANT OF AUTHORITY BY THE LOCAL GOVERNMENT TO USE AND OCCUPY
19 THE HIGHWAYS IN THE DELIVERY OF THE VIDEO SERVICE, SUBJECT TO THE LAWS OF
20 THIS STATE AND THE POLICE POWERS OF THE LOCAL GOVERNMENT.

21 15. THE TERM OF THE UNIFORM VIDEO SERVICE LICENSE.

22 16. A REQUIREMENT THAT THE PARTIES TO THE AGREEMENT ARE SUBJECT TO
23 AND MUST COMPLY WITH THIS CHAPTER.

24 D. EXCEPT AS OTHERWISE PROVIDED IN THIS CHAPTER, FROM AND AFTER
25 DECEMBER 31, 2019 A PERSON MAY NOT ACT AS A VIDEO SERVICE PROVIDER OR
26 CONSTRUCT OR OPERATE A VIDEO SERVICE NETWORK WITHIN THE BOUNDARIES OF A
27 LOCAL GOVERNMENT WITHOUT FIRST HAVING BEEN ISSUED AND CONTINUING TO HOLD A
28 UNIFORM VIDEO SERVICE LICENSE WITH A SERVICE AREA ENCOMPASSING THE
29 BOUNDARIES.

30 E. A LOCAL LICENSE SHALL REMAIN ENFORCEABLE IN ACCORDANCE WITH ITS
31 TERMS UNTIL TERMINATED UNDER SECTION 9-1412, SUBSECTION B.

32 9-1412. Incumbent cable operator; election on local license;
33 procedure to obtain uniform video service license
34 and terminate local license

35 A. FROM AND AFTER DECEMBER 31, 2019, AN INCUMBENT CABLE OPERATOR
36 MAY ELECT TO DO EITHER OF THE FOLLOWING:

37 1. CONTINUE TO OPERATE WITHIN A SERVICE AREA AS DEFINED IN THE
38 LOCAL LICENSE PURSUANT TO SECTION 9-1413.

39 2. TERMINATE THE INCUMBENT CABLE OPERATOR'S LOCAL LICENSE FOR A
40 SERVICE AREA BY APPLYING FOR AND OBTAINING A UNIFORM VIDEO SERVICE LICENSE
41 PURSUANT TO THIS ARTICLE.

42 B. ON OR BEFORE JULY 1, 2020, TO ELECT TO TERMINATE A LOCAL LICENSE
43 UNDER SUBSECTION A OF THIS SECTION IN THE SAME MANNER AS ANY OTHER VIDEO
44 SERVICE PROVIDER, AN INCUMBENT CABLE OPERATOR SHALL APPLY FOR A UNIFORM
45 VIDEO SERVICE LICENSE THAT INCLUDES ONLY THE SERVICE AREA THAT IS DEFINED

1 IN THE LOCAL LICENSE. IF AN INCUMBENT CABLE OPERATOR OBTAINS A UNIFORM
2 VIDEO SERVICE LICENSE FOR THE SERVICE AREA, BOTH OF THE FOLLOWING APPLY:

3 1. THE APPLICANT'S LOCAL LICENSE IS TERMINATED AS TO THE SERVICE
4 AREA BY OPERATION OF LAW FROM AND AFTER THE DATE THE LOCAL GOVERNMENT
5 ISSUES THE UNIFORM VIDEO SERVICE LICENSE.

6 2. THE INCUMBENT CABLE OPERATOR SHALL OPERATE WITHIN THE SERVICE
7 AREA DEFINED IN THE LOCAL LICENSE UNLESS THE INCUMBENT CABLE OPERATOR
8 ELECTS UNDER SECTION 9-1414, SUBSECTION C TO APPLY FOR A UNIFORM VIDEO
9 SERVICE LICENSE FOR A SERVICE AREA THAT CONSISTS OF THE BOUNDARIES OF THE
10 LOCAL GOVERNMENT.

11 9-1413. Incumbent cable operator; procedure to continue
12 operating under local license

13 A. IF AN INCUMBENT CABLE OPERATOR DOES NOT TIMELY ELECT TO
14 TERMINATE A LOCAL LICENSE FOR A SERVICE AREA PURSUANT TO SECTION 9-1412,
15 SUBSECTION B, THE PERSON SHALL CONTINUE TO OPERATE THE CABLE SYSTEM AS A
16 HOLDOVER CABLE OPERATOR WITHIN THE SERVICE AREA DEFINED IN THE LOCAL
17 LICENSE AND SHALL COMPLY WITH THE LOCAL LICENSE FOR AS LONG AS IT REMAINS
18 IN EFFECT FOR THE SERVICE AREA. THE LOCAL LICENSE IS NOT EFFECTIVE FOR
19 THE SERVICE AREA FROM AND AFTER THE DATE THE LOCAL LICENSE EXPIRES BY ITS
20 TERMS. THE LOCAL GOVERNMENT MAY NOT UNILATERALLY RENEW OR EXTEND THE TERM
21 OF THE LOCAL LICENSE FOR THE SERVICE AREA. THE LOCAL GOVERNMENT AND THE
22 HOLDOVER CABLE OPERATOR SHALL COMPLY WITH ALL OF THE FOLLOWING, WHICH
23 SHALL CONTINUE TO APPLY TO THE LOCAL LICENSE:

- 24 1. CHAPTER 5, ARTICLE 1.1 OF THIS TITLE.
25 2. SECTION 9-584.
26 3. CHAPTER 5, ARTICLE 8 OF THIS TITLE.
27 4. TITLE 11, CHAPTER 13, ARTICLE 1.

28 B. TO OPERATE WITHIN A SERVICE AREA FROM AND AFTER THE DATE THE
29 LOCAL LICENSE EXPIRES, THE HOLDOVER CABLE OPERATOR MUST APPLY FOR AND
30 OBTAIN A UNIFORM VIDEO SERVICE LICENSE IN THE SAME MANNER AS ANY OTHER
31 VIDEO SERVICE PROVIDER.

32 C. IF A HOLDOVER CABLE OPERATOR IS ISSUED A UNIFORM VIDEO SERVICE
33 LICENSE WITH A SERVICE AREA THAT INCLUDES THE SERVICE AREA DEFINED UNDER
34 THE LOCAL LICENSE WHILE OPERATING PURSUANT TO THE LOCAL LICENSE UNDER
35 SUBSECTION A OF THIS SECTION, THE UNIFORM VIDEO SERVICE LICENSE DOES NOT
36 BECOME EFFECTIVE UNTIL THE LOCAL LICENSE EXPIRES.

37 D. A HOLDOVER CABLE OPERATOR THAT ELECTS TO APPLY FOR A UNIFORM
38 VIDEO SERVICE LICENSE SHALL DO SO AT LEAST ONE MONTH BEFORE THE LOCAL
39 LICENSE EXPIRES.

40 9-1414. Uniform video service license; application; fees

41 A. TO OBTAIN A UNIFORM VIDEO SERVICE LICENSE, A PERSON SHALL FILE
42 WITH THE CLERK OF THE LOCAL GOVERNMENT AN APPLICATION AND AFFIDAVIT THAT
43 ARE SIGNED BY ONE OF THE PRINCIPAL EXECUTIVE OFFICERS OR GENERAL PARTNERS
44 OF THE APPLICANT AND THAT COMPLY WITH THIS SECTION.

1 B. THE APPLICATION AND AFFIDAVIT SHALL BE IN THE FORM REQUIRED BY
2 THE LOCAL GOVERNMENT AND SHALL BE REQUIRED TO CONTAIN ALL OF AND NOT MORE
3 THAN THE FOLLOWING:

4 1. EACH SERVICE AREA IN WHICH THE APPLICANT INTENDS TO PROVIDE
5 VIDEO SERVICE IN THE FORMAT AS DESCRIBED IN SECTION 9-1411, SUBSECTION C.
6 EXCEPT AS PROVIDED IN SECTION 9-1412, SUBSECTION B, PARAGRAPH 2, UNDER A
7 UNIFORM VIDEO SERVICE LICENSE THE BOUNDARIES OF THE LOCAL GOVERNMENT IS A
8 SINGLE SERVICE AREA AND THE SERVICE AREA CONSISTS OF ALL OF THE TERRITORY
9 WITHIN THE BOUNDARIES OF THAT LOCAL GOVERNMENT.

10 2. THE INFORMATION PRESCRIBED BY SECTION 9-1411, SUBSECTION C,
11 PARAGRAPHS 1 THROUGH 4. THE HOLDER SHALL NOTIFY THE LOCAL GOVERNMENT IN
12 WRITING OF CHANGES TO THIS INFORMATION WITHIN THIRTY DAYS AFTER THE CHANGE
13 OCCURS.

14 3. THE TERM OF THE UNIFORM VIDEO SERVICE LICENSE, WHICH MAY NOT
15 EXCEED TEN YEARS.

16 4. AN AGREEMENT TO PAY ALL LAWFUL FEES AND CHARGES IMPOSED BY THE
17 LOCAL GOVERNMENT.

18 C. AN INCUMBENT CABLE OPERATOR DESCRIBED IN SECTION 9-1412,
19 SUBSECTION B, PARAGRAPH 2 MAY ELECT TO APPLY FOR A UNIFORM VIDEO SERVICE
20 LICENSE FOR A SERVICE AREA THAT CONSISTS OF THE BOUNDARIES OF A LOCAL
21 GOVERNMENT.

22 D. IF THE LOCAL GOVERNMENT DETERMINES THAT THE APPLICATION AND
23 AFFIDAVIT ARE INCOMPLETE OR OTHERWISE DEFICIENT FOR FAILURE TO COMPLY WITH
24 THIS SECTION, THE LOCAL GOVERNMENT SHALL PROVIDE WRITTEN NOTICE TO THE
25 APPLICANT NOT LATER THAN FIFTEEN DAYS AFTER THE DATE OF FILING OF THE
26 APPLICATION AND AFFIDAVIT. THE WRITTEN NOTICE SHALL DO BOTH OF THE
27 FOLLOWING:

28 1. EXPLAIN THE INCOMPLETENESS OR DEFICIENCY IN DETAIL.

29 2. SPECIFY THE INFORMATION OR OTHER ITEMS THAT ARE NECESSARY UNDER
30 THIS SECTION FOR PROPER COMPLETION OF THE APPLICATION AND AFFIDAVIT.

31 E. THE LOCAL GOVERNMENT MAY NOT DO ANY OF THE FOLLOWING:

32 1. CHARGE A FEE FOR FILING OR PROCESSING AN APPLICATION, AFFIDAVIT,
33 NOTICE OR OTHER DOCUMENT UNDER THIS CHAPTER.

34 2. VOTE ON OR TAKE OTHER OFFICIAL ACTION REGARDING THE APPLICATION,
35 AFFIDAVIT, NOTICE OR OTHER DOCUMENT.

36 3. REQUIRE THE APPLICANT TO OBTAIN THE APPROVAL OF THE LOCAL
37 GOVERNMENT REGARDING THE APPLICATION, AFFIDAVIT, NOTICE OR OTHER DOCUMENT.

38 4. REQUIRE THE APPLICANT TO ENTER INTO AN AGREEMENT AS DESCRIBED IN
39 SECTION 9-1442, SUBSECTION I.

40 9-1415. Authority granted by uniform video service license;
41 conditions and limitations prohibited; providing
42 video service

43 A. NOT LATER THAN THIRTY DAYS AFTER THE DATE AN APPLICANT FILES A
44 COMPLETED APPLICATION AND AFFIDAVIT PURSUANT TO SECTION 9-1414, THE LOCAL
45 GOVERNMENT SHALL ISSUE A UNIFORM VIDEO SERVICE LICENSE TO THE APPLICANT IN

1 THE FORM PRESCRIBED BY SECTION 9-1411. IF THE LOCAL GOVERNMENT DOES NOT
2 NOTIFY THE APPLICANT ABOUT THE COMPLETENESS OF THE UNIFORM VIDEO SERVICE
3 LICENSE AGREEMENT WITHIN THE TIME PERIOD PRESCRIBED BY SECTION 9-1414,
4 SUBSECTION D OR ISSUE THE AGREEMENT WITHIN THE TIME PERIOD REQUIRED UNDER
5 THIS SUBSECTION, THE AGREEMENT SHALL BE CONSIDERED COMPLETE AND ISSUED TO
6 THE APPLICANT IN THE FORM SUBMITTED.

7 B. THE UNIFORM VIDEO SERVICE LICENSE ISSUED TO AN APPLICANT,
8 INCLUDING AN INCUMBENT CABLE OPERATOR, BY A LOCAL GOVERNMENT IS A
9 NONEXCLUSIVE LICENSE GRANTING TO THE HOLDER OF THE UNIFORM VIDEO SERVICE
10 LICENSE THE AUTHORITY FOR THE TERM REQUESTED IN THE APPLICATION TO DO ALL
11 OF THE FOLLOWING:

12 1. PROVIDE VIDEO SERVICE IN ALL SERVICE AREAS DESIGNATED IN THE
13 APPLICATION AND AFFIDAVIT FILED WITH THE LOCAL GOVERNMENT.

14 2. CONSTRUCT AND OPERATE A VIDEO SERVICE NETWORK IN THE HIGHWAYS IN
15 EACH SERVICE AREA IN COMPLIANCE WITH THIS CHAPTER AND ALL LOCAL LAWS THAT
16 ARE NOT IN CONFLICT OR OTHERWISE DO NOT CONFORM TO THIS CHAPTER OR THE
17 PURPOSES AND OBJECTIVES OF THIS CHAPTER.

18 3. OPERATE AND MAINTAIN FACILITIES INSTALLED IN THE HIGHWAYS IN THE
19 SERVICE AREA UNDER A LOCAL LICENSE PURSUANT TO ALL OF THE FOLLOWING:

20 (a) SECTION 9-506, SUBSECTIONS I AND J.

21 (b) SECTION 9-584.

22 (c) CHAPTER 5, ARTICLE 8 OF THIS TITLE AND TITLE 11, CHAPTER 13,
23 ARTICLE 1.

24 C. A LOCAL GOVERNMENT MAY NOT CONDITION OR LIMIT A UNIFORM VIDEO
25 SERVICE LICENSE BY IMPOSING ANY OBLIGATION OR REQUIREMENT THAT IS NOT
26 AUTHORIZED BY THIS CHAPTER, INCLUDING ANY OF THE FOLLOWING:

27 1. ANY OFFICE LOCATION, INSTITUTIONAL NETWORK OR OTHER BUILD-OUT,
28 LINE EXTENSION, INVESTMENT OR OTHER REQUIREMENTS RELATING TO THE OVERALL
29 SCOPE, EXTENT AND TIMING OF INFRASTRUCTURE, FACILITIES OR DEPLOYMENT OF
30 EQUIPMENT.

31 2. ANY REQUIREMENTS TO PAY TO ANY PERSON ANY APPLICATION, DOCUMENT,
32 LICENSE, SERVICE OR OTHER FEE, TAX, CHARGE OR ASSESSMENT THAT IS NOT
33 AUTHORIZED BY THIS CHAPTER.

34 D. A HOLDER OF A UNIFORM VIDEO SERVICE LICENSE SHALL PROVIDE VIDEO
35 SERVICE IN ACCORDANCE WITH THE CERTIFICATIONS MADE BY THE HOLDER IN EACH
36 APPLICATION AND AFFIDAVIT THAT THE HOLDER FILES WITH A LOCAL GOVERNMENT
37 PURSUANT TO THIS ARTICLE.

38 9-1416. Amendment of uniform video service license to add
39 service area

40 A. TO ADD ONE OR MORE NEW SERVICE AREAS TO A UNIFORM VIDEO SERVICE
41 LICENSE, THE HOLDER SHALL FILE WITH THE CLERK OF THE LOCAL GOVERNMENT AN
42 APPLICATION FOR AN AMENDMENT TO THE UNIFORM VIDEO SERVICE LICENSE TO ADD
43 EACH NEW SERVICE AREA.

1 B. THE APPLICATION IS SUBJECT TO THE SAME PROCEDURES, REQUIREMENTS,
2 LIMITATIONS AND TIME PERIODS AS AN APPLICATION FOR ISSUANCE OF A UNIFORM
3 VIDEO SERVICE LICENSE PURSUANT TO SECTIONS 9-1414 AND 9-1415.

4 9-1417. Termination of service

5 A. TO TERMINATE THE AUTHORITY TO PROVIDE VIDEO SERVICE TO AN
6 EXISTING SERVICE AREA AUTHORIZED UNDER THE UNIFORM VIDEO SERVICE LICENSE,
7 THE HOLDER OF THE UNIFORM VIDEO SERVICE LICENSE SHALL FILE WITH THE CLERK
8 OF THE LOCAL GOVERNMENT WRITTEN NOTICE OF THE TERMINATION.

9 B. THE HOLDER MAY TERMINATE SERVICE ON AND AFTER THE DATE THAT THE
10 HOLDER FILES THE WRITTEN NOTICE WITH THE CLERK OF THE LOCAL GOVERNMENT.

11 C. THE HOLDER SHALL:

12 1. COMPLY WITH APPLICABLE FEDERAL LAWS, INCLUDING RULES AND
13 REGULATIONS OF THE FEDERAL COMMUNICATIONS COMMISSION.

14 2. GIVE ALL AFFECTED SUBSCRIBERS AND LOCAL GOVERNMENTS NOTICE AT
15 LEAST NINETY DAYS BEFORE TERMINATION OF SERVICE IN ALL OF A SERVICE AREA
16 THAT CONSISTS OF THE BOUNDARIES OF THE LOCAL GOVERNMENT.

17 9-1418. Boundary change

18 EACH LOCAL GOVERNMENT WHOSE BOUNDARIES CHANGE SHALL NOTIFY IN A
19 TIMELY MANNER EACH VIDEO SERVICE PROVIDER THAT OPERATES IN THE BOUNDARIES.

20 9-1419. Transfer of uniform video service license

21 A. EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION OR OTHERWISE
22 REQUIRED BY FEDERAL LAW, INCLUDING RULES AND REGULATIONS OF THE FEDERAL
23 COMMUNICATIONS COMMISSION, A UNIFORM VIDEO SERVICE LICENSE IS FULLY
24 TRANSFERABLE TO ANY PERSON WHETHER THE TRANSFER ARISES THROUGH MERGER,
25 SALE, ASSIGNMENT, RESTRUCTURING, CHANGE OF CONTROL OR OTHER TYPE OF
26 TRANSACTION. A TRANSFER DOES NOT INCLUDE AN ASSIGNMENT OF A UNIFORM VIDEO
27 SERVICE LICENSE FOR THE PURPOSE OF SECURING INDEBTEDNESS. A TRANSFER MAY
28 INCLUDE LESS THAN ALL SERVICE AREAS ASSOCIATED WITH A UNIFORM VIDEO
29 SERVICE LICENSE.

30 B. THE HOLDER SHALL FILE WITH THE CLERK OF THE LOCAL GOVERNMENT
31 WRITTEN NOTICE OF THE TRANSFER OF THE UNIFORM VIDEO SERVICE LICENSE. ON
32 THE FILING OF NOTICE UNDER THIS SUBSECTION THE TRANSFEREE BECOMES THE
33 HOLDER.

34 9-1420. Extension

35 A. TO EXTEND THE TERM OF A UNIFORM VIDEO SERVICE LICENSE, THE
36 HOLDER OF THE UNIFORM VIDEO SERVICE LICENSE SHALL FILE WITH THE CLERK OF
37 THE LOCAL GOVERNMENT AT LEAST ONE MONTH BEFORE THE END OF THE TERM OF THE
38 UNIFORM VIDEO SERVICE LICENSE A NOTICE TO EXTEND THE TERM FOR A SPECIFIED
39 PERIOD NOT TO EXCEED TEN YEARS.

40 B. EFFECTIVE ON THE DATE THE HOLDER FILES THE WRITTEN NOTICE WITH
41 THE CLERK OF THE LOCAL GOVERNMENT, THE TERM IS EXTENDED FOR THE SPECIFIED
42 PERIOD FROM AND AFTER THE DATE OF THE END OF THE THEN-CURRENT TERM.

43 C. TRANSFERRING, AMENDING OR MODIFYING A UNIFORM VIDEO SERVICE
44 LICENSE UNDER OTHER SECTIONS OF THIS ARTICLE DOES NOT EXTEND THE TERM OF
45 THE UNIFORM VIDEO SERVICE LICENSE.

1 9-1421. Subscriber complaints

2 A. A SUBSCRIBER MAY SUBMIT COMPLAINTS ABOUT VIDEO SERVICE TO ANY OF
3 THE FOLLOWING:

- 4 1. THE LOCAL GOVERNMENT WHERE THE SUBSCRIBER RESIDES.
5 2. THE ATTORNEY GENERAL.
6 3. THE FEDERAL COMMUNICATIONS COMMISSION.
7 4. OTHER AUTHORITIES AS PROVIDED BY LAW.

8 B. A LOCAL GOVERNMENT MAY CHOOSE TO MONITOR AND ASSIST SUBSCRIBERS
9 WITH THE SUBSCRIBER SERVICE STANDARDS PURSUANT TO 47 CODE OF FEDERAL
10 REGULATIONS SECTION 76.309(c) OR TO BE IDENTIFIED ON BILLS TO SUBSCRIBERS
11 AS THE LOCAL FRANCHISE AUTHORITY FOR A SERVICE AREA CONSISTENT WITH RULES
12 OF THE FEDERAL COMMUNICATIONS COMMISSION.

13 ARTICLE 3. DUTIES OF VIDEO SERVICE PROVIDERS

14 9-1431. Video service; revocation for nonuse

15 A. NOT LATER THAN TWENTY-FOUR MONTHS AFTER THE DATE THAT A LOCAL
16 GOVERNMENT ISSUES A UNIFORM VIDEO SERVICE LICENSE PURSUANT TO SECTIONS
17 9-1414 AND 9-1415 OR AN AMENDED UNIFORM VIDEO SERVICE LICENSE PURSUANT TO
18 SECTION 9-1416, THE HOLDER OF THE UNIFORM VIDEO SERVICE LICENSE SHALL
19 OFFER AND PROVIDE VIDEO SERVICE TO AT LEAST ONE SUBSCRIBER WITHIN EACH
20 SERVICE AREA AUTHORIZED BY THE UNIFORM VIDEO SERVICE LICENSE OR AMENDED
21 UNIFORM VIDEO SERVICE LICENSE UNLESS THE HOLDER CANNOT MEET THE
22 REQUIREMENT FOR REASONS BEYOND THE HOLDER'S CONTROL.

23 B. IF A HOLDER FAILS TO COMPLY WITH SUBSECTION A OF THIS SECTION, A
24 LOCAL GOVERNMENT MAY REVOKE THE HOLDER'S UNIFORM VIDEO SERVICE LICENSE FOR
25 AFFECTED SERVICE AREAS.

26 9-1432. Reports; confidentiality; definition

27 A. A VIDEO SERVICE PROVIDER THAT IS NOT AN INCUMBENT CABLE OPERATOR
28 AND THAT HOLDS A UNIFORM VIDEO SERVICE LICENSE WITH A SERVICE AREA WITHIN
29 THE BOUNDARIES OF A LOCAL GOVERNMENT SHALL PREPARE AND SUBMIT TO THE LOCAL
30 GOVERNMENT A SEMIANNUAL REPORT THAT IDENTIFIES THE LOCATIONS WITHIN THE
31 BOUNDARIES THAT ARE ABLE TO RECEIVE VIDEO SERVICE FROM THE VIDEO SERVICE
32 PROVIDER. THIS REPORTING REQUIREMENT APPLIES UNTIL THE VIDEO SERVICE
33 PROVIDER HAS CONSTRUCTED ALL OF THE FACILITIES THE VIDEO SERVICE PROVIDER
34 INTENDS TO CONSTRUCT WITHIN THE BOUNDARIES OF THE LOCAL GOVERNMENT.

35 B. THE VIDEO SERVICE PROVIDER SHALL FILE THE REPORT WITH THE LOCAL
36 GOVERNMENT NOT LATER THAN TWENTY DAYS AFTER THE LAST DAY OF THE SECOND AND
37 FOURTH CALENDAR QUARTERS OF EACH YEAR.

38 C. INFORMATION CONTAINED IN A REPORT THAT IS SUBMITTED TO A LOCAL
39 GOVERNMENT PURSUANT TO THIS SECTION:

- 40 1. IS CONFIDENTIAL PROPRIETARY INFORMATION OF THE VIDEO SERVICE
41 PROVIDER.
42 2. IS NOT A PUBLIC RECORD.
43 3. MUST BE MANAGED SO THAT ANY CRITICAL INFRASTRUCTURE INFORMATION
44 CONTAINED IN THE REPORT IS PROTECTED AS PROVIDED BY LAW.

1 4. MAY NOT BE DISCLOSED TO ANY PERSON WHO IS NOT AN OFFICER OR
2 EMPLOYEE OF THE LOCAL GOVERNMENT UNLESS THE VIDEO SERVICE PROVIDER HAS
3 CONSENTED IN WRITING TO THE DISCLOSURE.

4 D. FOR THE PURPOSES OF THIS SECTION, "CRITICAL INFRASTRUCTURE
5 INFORMATION" HAS THE SAME MEANING PRESCRIBED IN SECTION 41-1801.

6 9-1433. Nondiscriminatory manner; compliance with standards
7 and federal law

8 A. A VIDEO SERVICE PROVIDER SHALL ACTIVATE AND OFFER VIDEO SERVICE
9 IN A NONDISCRIMINATORY MANNER WITHIN EACH SERVICE AREA AND MAY NOT DENY
10 ACCESS TO VIDEO SERVICE TO ANY GROUP OF POTENTIAL RESIDENTIAL SUBSCRIBERS
11 WITHIN A PARTICULAR PART OF A SERVICE AREA BECAUSE OF THE INCOME PROFILE
12 OF THE PERSONS WHO RESIDE IN THAT PART OF THE SERVICE AREA.

13 B. IN PROVIDING VIDEO SERVICE, A VIDEO SERVICE PROVIDER SHALL
14 COMPLY WITH ALL OF THE FOLLOWING:

15 1. 47 UNITED STATES CODE SECTION 551.

16 2. ALL ENGINEERING AND SAFETY CODES APPLICABLE TO THE VIDEO SERVICE
17 PROVIDER'S CONSTRUCTION PRACTICES AND INSTALLATION OF EQUIPMENT.

18 3. ANY TECHNICAL STANDARDS GOVERNING THE DESIGN, CONSTRUCTION AND
19 OPERATION OF A VIDEO SERVICE NETWORK REQUIRED BY FEDERAL LAW.

20 4. 47 CODE OF FEDERAL REGULATIONS PART 11, AS ADOPTED AND AS MAY BE
21 AMENDED BY THE FEDERAL COMMUNICATIONS COMMISSION, TO THE EXTENT THOSE
22 PROVISIONS REQUIRE A VIDEO SERVICE PROVIDER TO PARTICIPATE IN THE
23 EMERGENCY ALERT SYSTEM.

24 5. 47 CODE OF FEDERAL REGULATIONS SECTIONS 76.309, 76.1601,
25 76.1602, 76.1603, 76.1604, 76.1618, 76.1619, 76.1620, 76.1621 AND 76.1622,
26 AS ADOPTED AND AS MAY BE AMENDED BY THE FEDERAL COMMUNICATIONS COMMISSION,
27 ON STANDARDS GOVERNING THE QUALITY OF VIDEO SERVICE AND SUBSCRIBER
28 SERVICE. A VIDEO SERVICE PROVIDER MAY NOT BE REQUIRED TO COMPLY WITH ANY
29 SUBSCRIBER SERVICE STANDARDS THAT ARE MORE BURDENSOME THAN THOSE SET FORTH
30 IN THIS PARAGRAPH.

31 ARTICLE 4. LOCAL GOVERNMENTS

32 9-1441. Management of highways; local governments; permits or
33 licenses

34 A. IN MANAGING A HIGHWAY UNDER LOCAL LAWS AS PRESCRIBED IN SECTION
35 9-1411, SUBSECTION C, PARAGRAPH 9, A LOCAL GOVERNMENT MAY MANAGE THE USE
36 OF THE HIGHWAY, INCLUDING ALL OF THE FOLLOWING:

37 1. REQUIRING A VIDEO SERVICE PROVIDER THAT IS CONSTRUCTING,
38 INSTALLING, WORKING WITHIN, MAINTAINING OR REPAIRING FACILITIES IN, ON,
39 UNDER OR OVER ANY HIGHWAY TO OBTAIN A CONSTRUCTION, ENCROACHMENT OR
40 OCCUPANCY PERMIT FOR THE WORK.

41 2. INSPECTING THE CONSTRUCTION, INSTALLATION, MAINTENANCE OR REPAIR
42 WORK PERFORMED ON SUCH FACILITIES.

43 3. LIMITING THE INSTALLATION OF NEW AERIAL FACILITIES.

1 B. IF A VIDEO SERVICE PROVIDER REQUESTS A PERMIT OR INSPECTION, THE
2 LOCAL GOVERNMENT SHALL GRANT OR DENY THE REQUEST WITHIN THE TIME FRAME
3 THAT THE LOCAL GOVERNMENT HAS IN PLACE UNDER SECTION 9-835 OR 11-1605.

4 C. IF EMERGENCY RESPONSE WORK OR REPAIR BECOMES NECESSARY IN, ON,
5 UNDER OR OVER ANY HIGHWAY, A VIDEO SERVICE PROVIDER MAY BEGIN THAT WORK OR
6 REPAIR WITHOUT PRIOR APPROVAL FROM A LOCAL GOVERNMENT IF THE VIDEO SERVICE
7 PROVIDER NOTIFIES THE LOCAL GOVERNMENT AS PROMPTLY AS REASONABLY POSSIBLE
8 AFTER LEARNING THAT THE WORK OR REPAIR IS NECESSARY.

9 9-1442. Fees and charges; emergency alert; damage;
10 undergrounding; wireless facilities; definition

11 A. EXCEPT THE LICENSE FEE ON GROSS REVENUE AUTHORIZED BY SECTION
12 9-1443 AND TRANSACTION PRIVILEGE TAXES AS PROVIDED IN SUBSECTION B OF THIS
13 SECTION, A LOCAL GOVERNMENT MAY NOT LEVY A TAX, RENT, FEE OR CHARGE,
14 HOWEVER DENOMINATED, ON A VIDEO SERVICE PROVIDER FOR THE USE OF THE
15 HIGHWAYS TO PROVIDE VIDEO SERVICE OR LEVY A TAX, FEE OR CHARGE ON THE
16 PRIVILEGE OF ENGAGING IN THE BUSINESS OF PROVIDING VIDEO SERVICE IN THE
17 SERVICE AREA. TAXES, RENTS, FEES AND CHARGES INCLUDE ALL OF THE
18 FOLLOWING:

19 1. ACCESS CHANNEL SUPPORT EXCEPT FOR IN-KIND SERVICES, GOODS OR
20 PAYMENTS AS PROVIDED IN SUBSECTION C OF THIS SECTION.

21 2. RENTAL, APPLICATION, CONSTRUCTION, PERMIT, INSPECTION,
22 INCONVENIENCE AND OTHER FEES AND CHARGES RELATED TO A VIDEO SERVICE
23 PROVIDER'S USE OF THE HIGHWAYS, INCLUDING THE USE AUTHORIZED BY SUBSECTION
24 D OF THIS SECTION EXCEPT THAT A LOCAL GOVERNMENT MAY IMPOSE ON A VIDEO
25 SERVICE PROVIDER SOME OR ALL OF THE FEES AND CHARGES DESCRIBED IN THIS
26 PARAGRAPH. A VIDEO SERVICE PROVIDER SHALL OFFSET THE FEES AND CHARGES
27 IMPOSED PURSUANT TO THIS PARAGRAPH AGAINST THE NEXT LICENSE FEE PAYMENT
28 MADE PURSUANT TO SECTION 9-1443.

29 B. ANY TRANSACTION PRIVILEGE TAXES OTHERWISE AUTHORIZED BY LOCAL
30 LAW TO BE LEVIED ON THE BUSINESS OF PROVIDING VIDEO SERVICE OR IN RELATION
31 TO USE OF THE HIGHWAYS TO PROVIDE VIDEO SERVICE MAY BE LEVIED ON A VIDEO
32 SERVICE PROVIDER IF THE TAXES ARE LEVIED ONLY ON GROSS REVENUE AND THE
33 RATE OF THE TAXES IS SUBJECT TO THIS SUBSECTION. THIS SUBSECTION DOES NOT
34 AUTHORIZE THE IMPOSITION OF TRANSACTION PRIVILEGE TAXES ON INTERSTATE
35 TELECOMMUNICATIONS SERVICE. THE LICENSE FEE AND ANY TRANSACTION PRIVILEGE
36 TAXES LEVIED ON GROSS REVENUE CONSTITUTE A FRANCHISE FEE WITHIN THE
37 MEANING OF THE TERM IN 47 UNITED STATES CODE SECTION 542(g). THE TOTAL OF
38 THE RATES OF THE LICENSE FEE AND OF ANY TRANSACTION PRIVILEGE TAXES ON
39 GROSS REVENUE LEVIED OR ASSESSED BY A LOCAL GOVERNMENT FOR THE PRIVILEGE
40 OF PROVIDING VIDEO SERVICE AND RELATED USE OF THE HIGHWAYS TO PROVIDE
41 VIDEO SERVICE MAY NOT EXCEED A RATE OF FIVE PERCENT.

42 C. SUBSECTION A OF THIS SECTION DOES NOT PROHIBIT A LOCAL
43 GOVERNMENT FROM LEVYING FEES AND CHARGES ON A VIDEO SERVICE PROVIDER OR
44 ITS AFFILIATES PURSUANT TO SECTION 9-584 OR PURSUANT TO CHAPTER 5, ARTICLE

1 8 OF THIS TITLE OR TITLE 11, CHAPTER 13, ARTICLE 1 WITHOUT AN OFFSET
2 AGAINST LICENSE FEES.

3 D. A LOCAL GOVERNMENT MAY NOT REQUIRE A VIDEO SERVICE PROVIDER TO
4 PROVIDE IN-KIND GOODS OR SERVICES, MAKE IN-KIND PAYMENTS, ASSESSMENTS OR
5 OBLIGATIONS OR PAY A FEE IN ADDITION TO THE MONETARY LICENSE FEE LEVIED OR
6 ASSESSED AS PROVIDED IN SECTION 9-1443, EXCEPT FOR ANY OF THE FOLLOWING:

7 1. A LOCAL LAW MAY IMPOSE AND ENFORCE OBLIGATIONS EQUALLY AND
8 UNIFORMLY ON ALL VIDEO SERVICE PROVIDERS THAT ARE OPERATING WITHIN THE
9 BOUNDARIES OF A LOCAL GOVERNMENT AND ON ALL HOLDOVER CABLE OPERATORS THAT
10 HOLD A LOCAL LICENSE THAT REMAINS IN EFFECT UNDER SECTION 9-1414,
11 SUBSECTION A. UNDER THE LOCAL LAW, A LOCAL GOVERNMENT:

12 (a) MAY REQUIRE ALL VIDEO SERVICE PROVIDERS TO PROVIDE CHANNEL
13 CAPACITY FOR THE VIDEO SERVICE PROVIDER TO TRANSMIT PROGRAMMING OVER WHICH
14 THE VIDEO SERVICE PROVIDER EXERCISES NO EDITORIAL CONTROL EXCEPT AS
15 AUTHORIZED BY 47 UNITED STATES CODE SECTION 531(e). THE CHANNEL CAPACITY
16 SHALL BE LIMITED TO ONE OF THE FOLLOWING:

17 (i) NOT MORE THAN TWO CHANNELS OF PUBLIC, EDUCATIONAL OR
18 GOVERNMENTAL ACCESS PROGRAMMING IN THE BASIC SERVICE TIER OF THE VIDEO
19 SERVICE NETWORK AND NOT MORE THAN TWO CHANNELS OF NONCOMMERCIAL
20 GOVERNMENTAL PROGRAMMING, AT LEAST ONE OF WHICH MAY BE PROGRAMMED BY THE
21 FEDERAL GOVERNMENT, IN THE DIGITAL PROGRAMMING TIER OF THE VIDEO SERVICE
22 NETWORK.

23 (ii) NOT MORE THAN TWO LINES OF ACCESS PROGRAMMING WITH EACH LINE
24 OF PROGRAMMING CARRIED ON UP TO TWO STANDARD DEFINITION CHANNELS AND TWO
25 SWITCHED DIGITAL HIGH-DEFINITION CHANNELS.

26 (b) SHALL SPECIFY THE PROGRAMMING AND THE VIDEO SERVICE PROVIDER
27 MAY REQUIRE THAT THE CHANNELS REGULARLY DISPLAY AN UNOBTRUSIVE LOGO OR
28 OTHER SUITABLE IDENTIFIER OF THE VIDEO SERVICE PROVIDER, IF THE LOCAL
29 GOVERNMENT REQUIRES CHANNEL CAPACITY PURSUANT TO SUBDIVISION (a) OF THIS
30 PARAGRAPH.

31 (c) MAY REQUIRE ALL VIDEO SERVICE PROVIDERS TO INCUR COSTS AND
32 EXPENSES TO PROVIDE, MAINTAIN AND OPERATE FACILITIES AND EQUIPMENT OF THE
33 VIDEO SERVICE NETWORK, INCLUDING FACILITIES AND EQUIPMENT FOR SIGNAL
34 CARRIAGE, PROCESSING, REFORMATTING AND INTERCONNECTION FOR ALL OF THE
35 FOLLOWING:

36 (i) TO CONNECT THE VIDEO SERVICE NETWORK OR CABLE SYSTEM, AS IT MAY
37 BE RELOCATED FROM TIME TO TIME, TO TRANSMIT PROGRAMMING TO AND FROM
38 EXISTING LOCATIONS OF PUBLIC, EDUCATIONAL OR GOVERNMENTAL ACCESS
39 FACILITIES AND TO ALLOW MONITORING OF ACCESS PROGRAMMING AT THE
40 FACILITIES.

41 (ii) TO TRANSMIT PUBLIC, EDUCATIONAL AND GOVERNMENTAL ACCESS
42 CHANNELS TO SUBSCRIBERS WITH THE SAME PREVAILING QUALITY, FUNCTIONALITY
43 AND IDENTIFICATION AS OTHER CHANNELS.

44 (d) MAY REQUIRE ALL VIDEO SERVICE PROVIDERS AND INCUMBENT CABLE
45 OPERATORS TO PROVIDE AT NO INITIAL OR RECURRING CHARGE THE BASIC SERVICE

1 TIER OF VIDEO SERVICE TO ONE OUTLET AND ONE RECEIVING DEVICE AT EACH
2 BUILDING OCCUPIED BY THE LOCAL GOVERNMENT IF THE BUILDING IS NOT MORE THAN
3 TWO HUNDRED FEET FROM THE NEAREST TECHNICALLY AND COMMERCIALY FEASIBLE
4 POINT OF CONNECTION ON THE VIDEO SERVICE NETWORK.

5 2. A LOCAL GOVERNMENT MAY RETAIN NONRECEIVING EQUIPMENT THAT IT
6 OWNS WITHOUT CHARGE FOR THE EQUIPMENT'S USE AND AT THE LOCAL GOVERNMENT'S
7 EXPENSE, INCLUDING EQUIPMENT PREVIOUSLY PROVIDED BY AN INCUMBENT CABLE
8 OPERATOR.

9 E. A LOCAL LAW MAY NOT IMPOSE ANY OBLIGATION ON A VIDEO SERVICE
10 PROVIDER UNDER SUBSECTION D OF THIS SECTION THAT IS MORE BURDENSOME THAN
11 THE LEAST BURDENSOME REQUIREMENT UNDER ANY LOCAL LICENSE WITH A SERVICE
12 AREA WITHIN THE BOUNDARIES OF THE LOCAL GOVERNMENT THAT WAS IN EFFECT ON
13 FEBRUARY 1, 2019.

14 F. NONE OF THE ANNUAL FAIR MARKET VALUE OF ANY CHANNEL CAPACITY
15 PROVIDED PURSUANT TO SUBSECTION D, PARAGRAPH 1, SUBDIVISION (a), THE
16 ANNUAL COSTS AND EXPENSES INCURRED PURSUANT TO SUBSECTION D, PARAGRAPH 1,
17 SUBDIVISION (c) AND THE ANNUAL FAIR MARKET VALUE OF BASIC SERVICE AND LINE
18 EXTENSION PROVIDED PURSUANT TO SUBSECTION D, PARAGRAPH 1, SUBDIVISION (d)
19 MAY BE OFFSET AGAINST THE LICENSE FEE LEVIED OR ASSESSED UNDER THIS
20 SECTION.

21 G. NOTWITHSTANDING SUBSECTION A OF THIS SECTION, BY A
22 NONDISCRIMINATORY LOCAL LAW THAT IMPOSES AND ENFORCES THE OBLIGATIONS
23 EQUALLY AND UNIFORMLY ON ALL VIDEO SERVICE PROVIDERS OPERATING WITHIN THE
24 BOUNDARIES OF A LOCAL GOVERNMENT, A LOCAL GOVERNMENT MAY REQUIRE THAT A
25 VIDEO SERVICE PROVIDER BEAR ALL OF THE REASONABLE COSTS THAT ARE
26 ASSOCIATED WITH REPAIR AND RESTORATION OF DAMAGE CAUSED TO PRIVATE
27 PROPERTY OR HIGHWAYS BY THE REPAIR, REPLACEMENT, INSTALLATION,
28 CONSTRUCTION, MAINTENANCE OR OPERATION OF THE VIDEO SERVICE PROVIDER'S
29 FACILITIES IN THE HIGHWAYS AND THAT ARE IMPOSED ON A COMPETITIVELY NEUTRAL
30 AND NONDISCRIMINATORY BASIS IN RELATION TO COSTS BORNE BY
31 TELECOMMUNICATIONS CORPORATIONS UNDER SECTION 9-582, SUBSECTION C.

32 H. ON APPLICATION A LOCAL GOVERNMENT SHALL ISSUE TO A VIDEO SERVICE
33 PROVIDER OR ITS AFFILIATE A PERMIT TO ATTACH ALLOWED WI-FI RADIO EQUIPMENT
34 TO THE VIDEO SERVICE NETWORK IN THE HIGHWAYS WITHIN THE BOUNDARIES OF THE
35 LOCAL GOVERNMENT. THE PERMIT SHALL ALLOW INSTALLATION, OPERATION AND
36 MAINTENANCE OF ALLOWED WI-FI RADIO EQUIPMENT. A LOCAL GOVERNMENT MAY
37 REQUIRE THAT ALL OF THE ALLOWED WI-FI RADIO EQUIPMENT AT A SINGLE LOCATION
38 FIT WITHIN A FIFTEEN-INCH CUBE AND BE CONTAINED ENTIRELY WITHIN A
39 GROUND-MOUNTED PEDESTAL OR BE CONNECTED DIRECTLY TO AND MOUNTED AT THE
40 SAME HEIGHT AS ONE OF THE VIDEO SERVICE PROVIDER'S AERIAL HORIZONTAL
41 CONDUCTORS. THIS SUBSECTION DOES NOT DO ANY OF THE FOLLOWING:

42 1. PROHIBIT A LOCAL GOVERNMENT FROM REQUIRING A VIDEO SERVICE
43 PROVIDER TO PLACE UNDERGROUND AERIAL FACILITIES TO WHICH ALLOWED WI-FI
44 EQUIPMENT IS ATTACHED.

2. PROHIBIT THE IMPOSITION OF A TAX, RENT, FEE OR CHARGE ON REVENUE FROM SERVICES PROVIDED THROUGH ALLOWED WI-FI RADIO EQUIPMENT.

3. AFFECT THE AUTHORITY OF A LOCAL GOVERNMENT TO MANAGE THE HIGHWAYS WITHIN ITS BOUNDARIES OR TO EXERCISE ITS POLICE POWERS, INCLUDING REVIEW AND APPROVAL OF AN APPLICATION BEFORE ISSUING A PERMIT.

4. AFFECT ANY AUTHORITY OF A POLITICAL SUBDIVISION, INCLUDING AN AGRICULTURAL IMPROVEMENT DISTRICT OR ANY OTHER SPECIAL TAXING DISTRICT, THE LOCAL GOVERNMENT OR ANY OTHER PERSON CONTROLLING UTILITY POLES IN THE HIGHWAYS TO DENY, LIMIT, RESTRICT OR DETERMINE THE TERMS AND CONDITIONS FOR THE USE OF OR ATTACHMENT TO THE UTILITY POLES OR ATTACHMENTS TO OTHER POLES OF THE POLITICAL SUBDIVISION, LOCAL GOVERNMENT OR OTHER PERSON BY A VIDEO SERVICE PROVIDER.

I. THIS SECTION DOES NOT PROHIBIT A VIDEO SERVICE PROVIDER FROM AGREEING WITH A LOCAL GOVERNMENT TO PROVIDE IN-KIND SERVICES OR GOODS OR MAKE IN-KIND PAYMENTS IN THE SERVICE AREA THAT ARE OTHERWISE PROHIBITED BY THIS SECTION IF THE AGREEMENT WITH THE LOCAL GOVERNMENT IS NOT ENTERED INTO AS A CONDITION OF OPERATING IN THE SERVICE AREA UNDER A UNIFORM VIDEO SERVICE LICENSE ISSUED PURSUANT TO THIS CHAPTER. THE AGREEMENT MAY AUTHORIZE THE VIDEO SERVICE PROVIDER TO RETAIN LICENSE FEES AND TAXES COLLECTED FROM ITS SUBSCRIBERS IN THE AMOUNT OF ANY OFFSET TO LICENSE FEES SPECIFIED IN THE AGREEMENT.

J. FOR THE PURPOSES OF THIS SECTION, "ALLOWED WI-FI RADIO EQUIPMENT" MEANS RADIO EQUIPMENT THAT USES ONLY UNLICENSED RADIO SPECTRUM AND THAT ENABLES WIRELESS COMMUNICATION WITH A COMMUNICATIONS NETWORK FOR UNLICENSED SERVICES SUCH AS WI-FI SERVICE.

9-1443. License fee; requirements, conditions and limitations; pass through to subscribers

A. FOR THE PRIVILEGE OF A VIDEO SERVICE PROVIDER TO OCCUPY OR USE, IN WHOLE OR IN PART, ANY HIGHWAY WITHIN THE BOUNDARIES OF A LOCAL GOVERNMENT TO PROVIDE VIDEO SERVICE THROUGH A VIDEO SERVICE NETWORK, THE LOCAL GOVERNMENT MAY REQUIRE A VIDEO SERVICE PROVIDER TO PAY A LICENSE FEE TO THE LOCAL GOVERNMENT BASED ON THE GROSS REVENUE THAT THE VIDEO SERVICE PROVIDER RECEIVES FROM ITS SUBSCRIBERS LOCATED WITHIN THE BOUNDARIES OF THE LOCAL GOVERNMENT. THE LICENSE FEE BOTH:

1. IS SUBJECT TO THE LIMIT PRESCRIBED IN SECTION 9-1442, SUBSECTION B AND TO OFFSET, INCLUDING AMOUNTS COLLECTED FROM SUBSCRIBERS, AS PRESCRIBED BY SECTION 9-1442, SUBSECTIONS A AND I AND SUBSECTION D OF THIS SECTION.

2. SHALL BE DUE NO MORE OFTEN THAN QUARTERLY.

B. IF THE LOCAL GOVERNMENT REQUIRES A LICENSE FEE PURSUANT TO SUBSECTION A OF THIS SECTION, THE LOCAL GOVERNMENT SHALL ADOPT A LOCAL LAW THAT IMPOSES THE LICENSE FEE EQUALLY AND UNIFORMLY ON ALL OF THE FOLLOWING THAT ARE OPERATING WITHIN THE BOUNDARIES OF THE LOCAL GOVERNMENT:

1. VIDEO SERVICE PROVIDERS.

2. HOLDOVER CABLE OPERATORS.

1 C. A VIDEO SERVICE PROVIDER SHALL PAY THE ENTIRE AMOUNT OF THE
2 LICENSE FEE DIRECTLY TO THE LOCAL GOVERNMENT IN A CHECK, DRAFT OR NOTE OR
3 AUTOMATED CLEARING HOUSE TRANSACTION THAT IS PAYABLE IN LEGAL TENDER AS
4 DEFINED IN SECTION 43-1021.

5 D. A VIDEO SERVICE PROVIDER MAY DO ALL OF THE FOLLOWING:

6 1. PASS THE LICENSE FEE THROUGH TO AND COLLECT THE LICENSE FEE FROM
7 ITS SUBSCRIBERS WITHIN THE BOUNDARIES OF THE LOCAL GOVERNMENT, INCLUDING
8 FOR AN INCUMBENT CABLE OPERATOR ANY CHANGE IN LICENSE FEES THAT RESULTS
9 FROM A CHANGE IN THE APPLICABLE DEFINITION OF GROSS REVENUE.

10 2. DESIGNATE THE AMOUNT OF THE LICENSE FEE COLLECTED FROM EACH
11 SUBSCRIBER AS A SEPARATE LINE ITEM ON THE SUBSCRIBER'S BILL.

12 9-1444. Ownership of a video service network

13 A. A CITY OR TOWN MAY NOT ACQUIRE AN OWNERSHIP INTEREST IN A VIDEO
14 SERVICE NETWORK UNLESS THE OWNERSHIP INTEREST IS ACQUIRED AT NOT LESS THAN
15 FAIR MARKET VALUE.

16 B. EXCEPT FOR THE PURPOSES OF ACTING AS AN INTERMEDIARY IN A
17 TRANSFER OF A UNIFORM VIDEO SERVICE LICENSE, A COUNTY MAY NOT OWN A VIDEO
18 SERVICE NETWORK.

19 9-1445. Review and audit; bundling discounts; action to
20 recover underpayment or overpayment

21 A. NOT MORE THAN ONCE EVERY THREE YEARS, A LOCAL GOVERNMENT MAY ON
22 REASONABLE WRITTEN NOTICE AUDIT THE BUSINESS BOOKS AND RECORDS OF A VIDEO
23 SERVICE PROVIDER TO THE EXTENT NECESSARY TO ENSURE PAYMENT OF LICENSE FEES
24 PURSUANT TO THIS CHAPTER. THE LOCAL GOVERNMENT MAY NOT AUDIT ANY PERIOD
25 THAT ENDS MORE THAN THREE YEARS BEFORE THE DATE THAT THE NOTICE OF AUDIT
26 IS RECEIVED. ANY AUDITS OF A PERIOD OF TIME BEFORE ISSUANCE OF A UNIFORM
27 VIDEO SERVICE LICENSE SHALL BE CONDUCTED PURSUANT TO THE LOCAL LAWS IN
28 EFFECT DURING THE PERIOD OF TIME.

29 B. EXCEPT AS OTHERWISE PROVIDED BY FEDERAL LAW, IF A VIDEO SERVICE
30 PROVIDER OFFERS VIDEO SERVICE BUNDLED WITH OTHER SERVICES THAT ARE NOT
31 VIDEO SERVICE FOR A SINGLE DISCOUNTED PRICE, ALL OF THE FOLLOWING APPLY:

32 1. THE METHOD THAT THE VIDEO SERVICE PROVIDER USES TO DETERMINE
33 GROSS REVENUE SUBJECT TO LICENSE FEES BY ALLOCATING THE SINGLE DISCOUNTED
34 PRICE AMONG THE BUNDLE OF VIDEO SERVICE AND NONVIDEO SERVICES SHALL BE
35 REASONABLE AND SUPPORTED BY THE VIDEO SERVICE PROVIDER'S BOOKS AND
36 RECORDS.

37 2. THE LOCAL GOVERNMENT SHALL ACCEPT AS REASONABLE, FOR PURPOSES OF
38 MEETING THE VIDEO SERVICE PROVIDER'S BURDEN OF PROOF, AN ALLOCATION BASED
39 ON AN OBJECTIVE AND VERIFIABLE METHOD USING THE BOOKS AND RECORDS THAT THE
40 VIDEO SERVICE PROVIDER KEPT IN THE REGULAR COURSE OF BUSINESS FOR OTHER
41 PURPOSES, INCLUDING NONTAX PURPOSES.

42 3. A VIDEO SERVICE PROVIDER MAY NOT USE BUNDLED OFFERINGS AS A
43 MEANS TO EVADE PAYING LICENSE FEES.

44 C. THE LOCAL GOVERNMENT AND THE VIDEO SERVICE PROVIDER SHALL EACH
45 PAY ITS OWN COSTS AND FEES RELATING TO EACH AUDIT PERFORMED PURSUANT TO

1 SUBSECTION A OF THIS SECTION. IF THE SUM DETERMINED TO BE UNDERPAID
2 EXCEEDS FIVE PERCENT OF THE TOTAL FEES THAT THE AUDIT DETERMINES SHOULD
3 HAVE BEEN PAID FOR THE PERIOD, THE VIDEO SERVICE PROVIDER SHALL PAY THE
4 LOCAL GOVERNMENT'S REASONABLE COSTS OF THE AUDIT.

5 D. THE RATE OF INTEREST FOR BOTH UNDERPAYMENTS AND OVERPAYMENTS IS
6 THE FEDERAL SHORT-TERM RATE DETERMINED PURSUANT TO 26 UNITED STATES CODE
7 SECTION 6621(b), PLUS THREE PERCENTAGE POINTS.

8 E. A PERSON THAT PERFORMS A REVIEW AND AUDIT UNDER SUBSECTION A OF
9 THIS SECTION MAY NOT RECEIVE COMPENSATION THAT IS BASED, IN WHOLE OR IN
10 PART, ON EITHER OF THE FOLLOWING:

11 1. FINDING A PARTICULAR RESULT.

12 2. THE AMOUNT OF ANY UNDERPAYMENT OR OVERPAYMENT OF THE LICENSE FEE
13 THAT IS IDENTIFIED BECAUSE OF THE REVIEW AND AUDIT.

14 F. A COMPLAINT BY A LOCAL GOVERNMENT FOR UNDERPAYMENT OF A LICENSE
15 FEE FROM A VIDEO SERVICE PROVIDER OR BY A VIDEO SERVICE PROVIDER FOR
16 OVERPAYMENT OF A LICENSE FEE TO A LOCAL GOVERNMENT SHALL BE MADE PURSUANT
17 TO ARTICLE 5 OF THIS CHAPTER.

18 G. A COMPLAINT FOR A VIOLATION OF THE LICENSE FEE OBLIGATIONS UNDER
19 THIS CHAPTER MAY NOT BE MADE UNLESS A WRITTEN DEMAND BY A LOCAL GOVERNMENT
20 FOR PAYMENT OF THE LICENSE FEES OR A WRITTEN DEMAND BY A VIDEO SERVICE
21 PROVIDER FOR REFUND OF LICENSE FEES IS MADE WITHIN FOUR MONTHS AFTER THE
22 LOCAL GOVERNMENT OR VIDEO SERVICE PROVIDER REALIZES IT HAS BEEN DAMAGED OR
23 KNOWS OR REASONABLY SHOULD KNOW OF THE DAMAGE CAUSED BY THE ALLEGED
24 VIOLATION.

25 H. A COMPLAINT MUST BE FILED PURSUANT TO ARTICLE 5 OF THIS CHAPTER
26 WITHIN TWO YEARS AFTER THE WRITTEN DEMAND IS MADE PURSUANT TO THIS
27 SUBSECTION BUT NOT SOONER THAN FOUR MONTHS AFTER THE WRITTEN DEMAND.

28 ARTICLE 5. ENFORCEMENT

29 9-1451. Enforcement: office of administrative hearings: fees:
30 fund

31 A. A LOCAL GOVERNMENT MAY FILE A WRITTEN COMPLAINT AGAINST A VIDEO
32 SERVICE PROVIDER AND A VIDEO SERVICE PROVIDER MAY FILE A WRITTEN COMPLAINT
33 AGAINST A LOCAL GOVERNMENT ALLEGING A VIOLATION OF THIS CHAPTER OR THE
34 UNIFORM VIDEO SERVICE LICENSE AGREEMENT. UNLESS OTHERWISE PROVIDED IN
35 SECTION 9-1445, SUBSECTIONS F, G AND H OR THIS SECTION:

36 1. ALL COMPLAINTS MUST BE FILED WITH THE OFFICE OF ADMINISTRATIVE
37 HEARINGS.

38 2. THE COMPLAINANT MUST SERVE A COPY OF THE COMPLAINT ON THE PARTY
39 THAT IS THE SUBJECT OF THE COMPLAINT BY PERSONAL DELIVERY OR CERTIFIED
40 MAIL, RETURN RECEIPT REQUESTED, OR BY ANY OTHER METHOD REASONABLY
41 CALCULATED TO EFFECT ACTUAL NOTICE TO THE LOCAL GOVERNMENT'S LAST ADDRESS
42 OF RECORD FOR THE PARTY THAT IS THE SUBJECT OF THE COMPLAINT.

43 3. THE PARTY THAT IS THE SUBJECT OF THE COMPLAINT MAY FILE A
44 RESPONSE TO THE COMPLAINT WITH THE OFFICE OF ADMINISTRATIVE HEARINGS
45 WITHIN TWENTY DAYS AFTER SERVICE PURSUANT TO PARAGRAPH 2 OF THIS

1 SUBSECTION. RESPONSES SHALL BE SERVED PURSUANT TO PARAGRAPH 2 OF THIS
2 SUBSECTION.

3 B. BEFORE FILING A COMPLAINT PURSUANT TO THIS SECTION ALL OF THE
4 FOLLOWING APPLY:

5 1. THE COMPLAINANT MUST PROVIDE NOTICE OF THE ALLEGED VIOLATION OF
6 THIS CHAPTER TO THE PARTY THAT IS THE SUBJECT OF THE COMPLAINT.

7 2. THE PARTY THAT IS THE SUBJECT OF THE COMPLAINT MUST HAVE A
8 PERIOD OF NOT LESS THAN TWENTY DAYS AFTER THE DATE IT RECEIVES THE NOTICE
9 TO RESOLVE THE ALLEGED VIOLATION.

10 C. A HEARING BEFORE THE OFFICE OF ADMINISTRATIVE HEARINGS SHALL BE
11 HELD IF A COMPLAINT THAT COMPLIES WITH THIS SECTION IS FILED WITH THE
12 OFFICE OF ADMINISTRATIVE HEARINGS. UNLESS OTHER DEADLINES ARE ESTABLISHED
13 FOR A PARTICULAR COMPLAINT, ALL OF THE FOLLOWING APPLY:

14 1. THE HEARING SHALL BE HELD WITHIN TWO MONTHS AFTER THE DATE THAT
15 THE COMPLAINT IS FILED AND SERVICE IS COMPLETED PURSUANT TO SUBSECTION A
16 OF THIS SECTION.

17 2. THE DATE SCHEDULED FOR THE HEARING MAY BE ADVANCED OR DELAYED ON
18 THE AGREEMENT OF THE PARTIES OR ON A SHOWING OF GOOD CAUSE.

19 D. THE OFFICE OF ADMINISTRATIVE HEARINGS SHALL PREPARE AND SERVE A
20 NOTICE OF HEARING ON ALL PARTIES AT LEAST ONE MONTH BEFORE THE HEARING
21 THAT STATES THE TIME AND PLACE OF THE HEARING.

22 E. A PREHEARING CONFERENCE MAY BE HELD PURSUANT TO SECTION
23 41-1092.05.

24 F. UNLESS IT CONFLICTS WITH THE REQUIREMENTS OF THIS SECTION, THE
25 HEARING SHALL BE CONDUCTED PURSUANT TO SECTION 41-1092.07.

26 G. THE COMPLAINANT HAS THE BURDEN OF PERSUASION AT A HEARING UNDER
27 THIS SECTION.

28 H. THE DECISION OF THE ADMINISTRATIVE LAW JUDGE IS THE FINAL
29 ADMINISTRATIVE DECISION WITH RESPECT TO THE COMPLAINT. THE OFFICE OF
30 ADMINISTRATIVE HEARINGS SHALL SERVE A COPY OF THE ADMINISTRATIVE LAW
31 JUDGE'S DECISION ON ALL PARTIES. THE FINAL ADMINISTRATIVE DECISION MAY BE
32 APPEALED TO THE SUPERIOR COURT PURSUANT TO TITLE 12, CHAPTER 7, ARTICLE 6.
33 NOTWITHSTANDING SECTION 12-910, THE SUPERIOR COURT PROCEEDING SHALL BE A
34 TRIAL DE NOVO.

35 I. A PARTY MAY MOVE FOR REHEARING PURSUANT TO SECTION 41-1092.09
36 AND THE OFFICE OF ADMINISTRATIVE HEARINGS SHALL RULE ON THE MOTION. MOVING
37 FOR REHEARING OR REVIEW IS NOT NECESSARY FOR THE PARTY TO SEEK JUDICIAL
38 REVIEW OF THE DECISION OF THE ADMINISTRATIVE LAW JUDGE UNDER SUBSECTION H
39 OF THIS SECTION.

40 J. SERVICE IS COMPLETE ON PERSONAL SERVICE OR FIVE DAYS AFTER THE
41 DATE THAT THE OFFICE OF ADMINISTRATIVE HEARINGS MAILES THE FINAL
42 ADMINISTRATIVE DECISION TO EACH PARTY'S LAST KNOWN ADDRESS OF RECORD WITH
43 THE LOCAL GOVERNMENT.

44 K. THE OFFICE OF ADMINISTRATIVE HEARINGS SHALL ADOPT RULES PURSUANT
45 TO TITLE 41, CHAPTER 6 TO ADMINISTER HEARINGS UNDER THIS CHAPTER.

1 L. THE OFFICE OF ADMINISTRATIVE HEARINGS SHALL ESTABLISH,
2 ADMINISTER AND COLLECT FEES IN AN AMOUNT TO BE DETERMINED BY THE DIRECTOR
3 OF THE OFFICE OF ADMINISTRATIVE HEARINGS. THE DIRECTOR SHALL DEPOSIT,
4 PURSUANT TO SECTIONS 35-146 AND 35-147, ALL MONIES IN THE VIDEO SERVICE
5 PROVIDER COMPLAINT FUND ESTABLISHED BY SUBSECTION M OF THIS SECTION.

6 M. THE VIDEO SERVICE PROVIDER COMPLAINT FUND IS ESTABLISHED
7 CONSISTING OF MONIES COLLECTED PURSUANT TO SUBSECTION L OF THIS SECTION.
8 THE OFFICE OF ADMINISTRATIVE HEARINGS SHALL ADMINISTER THE FUND. MONIES
9 IN THE FUND ARE CONTINUOUSLY APPROPRIATED. THE OFFICE OF ADMINISTRATIVE
10 HEARINGS SHALL USE THE MONIES IN THE FUND FOR THE PURPOSE OF ADMINISTERING
11 THE DUTIES SPECIFIED IN THIS ARTICLE.

12 9-1452. Statute of limitations; costs and attorney fees;
13 federal subscriber service requirements

14 A. EXCEPT AS PROVIDED IN SECTION 9-1445, SUBSECTIONS F, G AND H, A
15 COMPLAINT UNDER THIS ARTICLE MUST BE FILED WITHIN TWO YEARS AFTER THE
16 COMPLAINANT REALIZES IT HAS BEEN DAMAGED AND KNOWS OR REASONABLY SHOULD
17 KNOW THE CAUSE, SOURCE, ACT, EVENT, INSTRUMENTALITY OR CONDITION THAT
18 CAUSED OR CONTRIBUTED TO THE ALLEGED VIOLATION.

19 B. EACH PARTY TO A DISPUTE UNDER THIS CHAPTER SHALL BEAR ITS OWN
20 ATTORNEY FEES AND COSTS.

21 C. THIS ARTICLE DOES NOT APPLY TO CLAIMS THAT A VIDEO SERVICE
22 PROVIDER HAS FAILED TO MEET SUBSCRIBER SERVICE STANDARDS PRESCRIBED BY
23 SECTION 9-1433, SUBSECTION B, PARAGRAPH 5 OR HAS VIOLATED TITLE 44,
24 CHAPTER 10, ARTICLE 7. CLAIMS OF VIOLATIONS OF FEDERAL SUBSCRIBER SERVICE
25 STANDARDS SHALL BE MADE PURSUANT TO THE PROCEDURE ESTABLISHED UNDER
26 FEDERAL LAW.

27 Sec. 2. Section 41-1092.01, Arizona Revised Statutes, is amended to
28 read:

29 41-1092.01. Office of administrative hearings; director;
30 powers and duties; fund

31 A. An office of administrative hearings is established.

32 B. The governor shall appoint the director pursuant to section
33 38-211. At a minimum, the director shall have the experience necessary for
34 appointment as an administrative law judge. The director also shall
35 possess supervisory, management and administrative skills, as well as
36 knowledge and experience relating to administrative law.

37 C. The director shall:

38 1. Serve as the chief administrative law judge of the office.

39 2. Make and execute the contracts and other instruments that are
40 necessary to perform the director's duties.

41 3. Subject to chapter 4, article 4 of this title, hire employees,
42 including full-time administrative law judges, and contract for special
43 services, including temporary administrative law judges, that are
44 necessary to carry out this article. An administrative law judge employed
45 or contracted by the office shall have graduated from an accredited

1 college of law or shall have at least two years of administrative or
2 managerial experience in the subject matter or agency section the
3 administrative law judge is assigned to in the office.

4 4. Make rules that are necessary to carry out this article,
5 including rules governing ex parte communications in contested cases.

6 5. Submit a report to the governor, speaker of the house of
7 representatives and president of the senate by November 1 of each year
8 describing the activities and accomplishments of the office. The
9 director's annual report shall include a summary of the extent and effect
10 of agencies' utilization of administrative law judges, court reporters and
11 other personnel in proceedings under this article and recommendations for
12 changes or improvements in the administrative procedure act or any
13 agency's practice or policy with respect to the administrative procedure
14 act.

15 6. Secure, compile and maintain all decisions, opinions or reports
16 of administrative law judges issued pursuant to this article and the
17 reference materials and supporting information that may be appropriate.

18 7. Develop, implement and maintain a program for the continuing
19 training and education of administrative law judges and agencies in regard
20 to their responsibilities under this article. The program shall require
21 that an administrative law judge receive training in the technical and
22 subject matter areas of the sections to which the administrative law judge
23 is assigned.

24 8. Develop, implement and maintain a program of evaluation to aid
25 the director in the evaluation of administrative law judges appointed
26 pursuant to this article that includes comments received from the public.

27 9. Annually report the following to the governor, the president of
28 the senate and the speaker of the house of representatives by December 1
29 for the prior fiscal year:

30 (a) The number of administrative law judge decisions rejected or
31 modified by agency heads.

32 (b) By category, the number and disposition of motions filed
33 pursuant to section 41-1092.07, subsection A to disqualify office
34 administrative law judges for bias, prejudice, personal interest or lack
35 of expertise.

36 (c) By agency, the number and type of violations of section
37 41-1009.

38 10. Schedule hearings pursuant to section 41-1092.05 upon the
39 request of an agency or the filing of a notice of appeal pursuant to
40 section 41-1092.03.

41 D. The director shall not require legal representation to appear
42 before an administrative law judge.

43 E. Except as provided in subsection F of this section, all state
44 agencies supported by state general fund sources, unless exempted by this
45 article, and the registrar of contractors shall use the services and

1 personnel of the office to conduct administrative hearings. All other
2 agencies shall contract for services and personnel of the office to
3 conduct administrative hearings.

4 F. An agency head, board or commission that directly conducts an
5 administrative hearing as an administrative law judge is not required to
6 use the services and personnel of the office for that hearing.

7 G. Each state agency, and each political subdivision contracting
8 for office services pursuant to subsection I of this section, shall make
9 its facilities available, as necessary, for use by the office in
10 conducting proceedings pursuant to this article.

11 H. The office shall employ full-time administrative law judges to
12 conduct hearings required by this article or other laws as follows:

13 1. The director shall assign administrative law judges from the
14 office to an agency, on either a temporary or a permanent basis, at
15 supervisory or other levels, to preside over contested cases and
16 appealable agency actions in accordance with the special expertise of the
17 administrative law judge in the subject matter of the agency.

18 2. The director shall establish the subject matter and agency
19 sections within the office that are necessary to carry out this
20 article. Each subject matter and agency section shall provide training in
21 the technical and subject matter areas of the section as prescribed in
22 subsection C, paragraph 7 of this section.

23 I. If the office cannot furnish an office administrative law judge
24 promptly in response to an agency request, the director may contract with
25 qualified individuals to serve as temporary administrative law
26 judges. These temporary administrative law judges are not employees of
27 this state.

28 J. The office may provide administrative law judges on a contract
29 basis to any governmental entity to conduct any hearing not covered by
30 this article. The director may enter into contracts with political
31 subdivisions of this state, and these political subdivisions may contract
32 with the director for the purpose of providing administrative law judges
33 and reporters for administrative proceedings or informal dispute
34 resolution. The contract may define the scope of the administrative law
35 judge's duties. Those duties may include the preparation of findings,
36 conclusions, decisions or recommended decisions or a recommendation for
37 action by the political subdivision. For these services, the director
38 shall request payment for services directly from the political subdivision
39 for which the services are performed, and the director may accept payment
40 on either an advance or reimbursable basis.

41 K. The office shall apply monies received pursuant to subsections E
42 and J of this section to offset its actual costs for providing personnel
43 and services.

1 L. THE OFFICE SHALL RECEIVE COMPLAINTS AGAINST A LOCAL GOVERNMENT
2 OR VIDEO SERVICE PROVIDER AS DEFINED IN SECTION 9-1401 AND SHALL COMPLY
3 WITH THE DUTIES IMPOSED ON THE OFFICE PURSUANT TO TITLE 9, CHAPTER 13.

4 Sec. 3. Legislative findings

5 Pursuant to section 41-1107, Arizona Revised Statutes, the
6 legislature has determined that it is reasonable and necessary to promote
7 a matter of statewide concern by regulating the licensure and provision of
8 video service to promote all of the following:

9 1. Provision of competitive video, telecommunications and
10 information service throughout this state.

11 2. More uniform regulation of competitive video service throughout
12 this state.

13 3. Streamlined licensing by local governments and more uniform
14 terms and conditions for video service providers that use highways to
15 provide video and other services over video service networks.

16 4. Continued management of local governments' use of their highways
17 with reasonable burdens on construction and maintenance across boundaries
18 between local governments for video service providers to use highways.

19 5. Continued levying of license fees by local governments on
20 subscriber service revenues derived from operating video service networks
21 to provide video service.

22 6. Support for federal subscriber service standards.

APPROVED BY THE GOVERNOR MAY 16, 2018.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MAY 16, 2018.

State of Arizona
House of Representatives
Fifty-fourth Legislature
First Regular Session
2019

CHAPTER 76

HOUSE BILL 2229

AN ACT

AMENDING SECTIONS 9-1401, 9-1415, 9-1441, 9-1442, 9-1444, 9-1445 AND 9-1451, ARIZONA REVISED STATUTES; AMENDING TITLE 11, ARIZONA REVISED STATUTES, BY ADDING CHAPTER 14; AMENDING SECTION 41-1092.01, ARIZONA REVISED STATUTES; RELATING TO VIDEO SERVICE PROVIDERS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Section 9-1401, Arizona Revised Statutes, is amended to
3 read:

4 9-1401. Definitions

5 In this chapter, unless the context otherwise requires:

6 1. "Affiliate" means a person that directly or indirectly, through
7 one or more intermediaries, controls, is controlled by or is under common
8 control with a video service provider.

9 2. "Agreement" means any agreement or contract.

10 3. "Boundaries of a local government" or "boundaries" means:—

11 ~~(a) For a city or town, all of the area within the corporate limits~~
12 ~~of the city or town.~~

13 ~~(b) For a county, all of the area of the county that is not within~~
14 ~~the corporate limits of any city or town, including unincorporated~~
15 ~~territory that is surrounded on all sides by a combination of one or more~~
16 ~~cities, towns or Indian reservations.~~

17 4. "Cable operator" has the same meaning prescribed in 47 United
18 States Code section 522.

19 5. "Cable service" has the same meaning prescribed in 47 United
20 States Code section 522.

21 6. "Cable system" has the same meaning prescribed in 47 United
22 States Code section 522.

23 7. "Commercial mobile service provider" means a person that
24 provides commercial mobile service as defined in 47 United States Code
25 section 332(d) or commercial mobile radio service as described in 47 Code
26 of Federal Regulations section ~~20.9~~ 20.3.

27 8. "Day" means a calendar day, except a Saturday or Sunday or a
28 holiday prescribed in section 1-301.

29 9. "Gross revenue":

30 (a) Means all cash, credits, property of any kind or nature or
31 other consideration that is received directly or indirectly by a video
32 service provider, its affiliates, or any person, firm or corporation in
33 which the video service provider has a financial interest or that has a
34 financial interest in the video service provider and that is derived from
35 the video service provider's operation of its video service network to
36 provide video service in the service area.

37 (b) Includes all revenue from charges for video service to
38 subscribers and all charges for installation, removal, connection or
39 reinstatement of equipment necessary for a subscriber to receive video
40 service and any other receipts from subscribers derived from the video
41 service provider's operation of the video service network to provide video
42 service, including receipts from forfeited deposits, sale or rental of
43 equipment to provide video service, late charges, interest and sale of
44 program guides.

1 (c) Does not include:

2 (i) Any revenue not received, even if billed, such as bad debt net
3 of any recoveries of bad debt or any refunds, credits, allowances or
4 discounts to subscribers to the extent that the refund, rebate, credit,
5 allowance or discount is attributed to video service.

6 (ii) Revenue from commercial advertising on the video service
7 network, the use or lease of studio facilities of the video service
8 network, internet access service, the use or lease of its facilities
9 located in the highways, the use or lease of leased access channels or
10 bandwidth, the use or lease of towers, the production of video programming
11 by the video service provider, the sale, exchange, use or cablecast of any
12 programming by the video service provider in the service area, sales to
13 the video service provider's subscribers by programmers of home shopping
14 services, reimbursements paid by programmers for launch fees or marketing
15 expenses, license fees, taxes or other fees or charges that the video
16 service provider collects and pays to any governmental authority, any
17 increase in the value of any stock, security or asset, or any dividends or
18 other distributions made from any stock or securities.

19 10. "Highway" means all roads, streets and alleys and other
20 dedicated public rights-of-way that are operated and maintained by a local
21 government.

22 11. "Holder" means a video service provider that has been issued a
23 uniform video service license pursuant to this chapter.

24 12. "Holdover cable operator" means an incumbent cable operator
25 that elects under sections 9-1412 and 9-1413 to continue to operate within
26 its service area pursuant to its local license.

27 13. "Incumbent cable operator" means a cable operator or other
28 video service provider that on December 31, 2019 is providing video
29 service in this state pursuant to a local license.

30 14. "Information service" has the same meaning prescribed in 47
31 United States Code section 153.

32 15. "Interactive computer service" has the same meaning prescribed
33 in 47 United States Code section 230(f).

34 16. "License" means a franchise as defined in 47 United States Code
35 section 522.

36 17. "License fee" means a license fee imposed by a local government
37 on a video service provider for using the highways to provide and for the
38 privilege of providing video service.

39 18. "Local government" means any city, including a charter city, ~~OR~~
40 town ~~or county~~.

41 19. "Local law" means any charter, code, ordinance, resolution,
42 regulation or other law of a local government.

43 20. "Local license" means any license, agreement, permit or similar
44 authorization that meets all of the following:

1 (a) Allows a person to construct or operate a video service network
2 within the boundaries of a local government.

3 (b) Is issued, granted, approved, extended or renewed by the local
4 government before January 1, 2020 pursuant to the authority of any
5 federal, state or local law in effect at the time of the issuance, grant,
6 approval, extension or renewal.

7 (c) Is effective under federal, state or local law on December 31,
8 2019 for the person to continue to construct or operate a video service
9 network within the boundaries of a local government.

10 21. "Multichannel video programming distributor" has the same
11 meaning prescribed in 47 United States Code section 522.

12 22. "Service area" means that part of the boundaries of a local
13 government within which a video service provider is authorized to provide
14 video service pursuant to a uniform video service license or a local
15 license.

16 23. "Subscriber" means any person in this state that purchases
17 video service. Subscriber does not include any person that purchases
18 video service for resale and that, on resale, is required to pay a license
19 fee pursuant to this chapter or the terms of a local license.

20 24. "Telecommunications":

21 (a) Means the transmission, between or among points specified by
22 the user, of information of the user's choosing, without change in the
23 form or content of the information sent and received, regardless of the
24 facilities, equipment or technology used.

25 (b) Does not include commercial mobile radio service, pay phone
26 service, interstate service or cable service.

27 25. "Telecommunications provider" means a person that is required
28 to obtain from the corporation commission a certificate of public
29 convenience and necessity to provide telecommunications service.

30 26. "Telecommunications service" means the offering of
31 telecommunications for a fee directly to the public, or to such users as
32 to be effectively available directly to the public, regardless of the
33 equipment, facilities or technology used.

34 27. "Uniform video service license" means a license that is issued
35 by a local government in the form of a uniform video service license
36 agreement as adopted pursuant to section 9-1411.

37 28. "Video service":

38 (a) Means the provision of multichannel video programming generally
39 considered comparable to video programming delivered by a television
40 broadcast station, video service or other digital television service,
41 whether provided as part of a tier, on demand or on a per-channel basis,
42 without regard to the technology used to deliver the video service,
43 including internet protocol technology or any successor technology.

44 (b) Includes cable service.

1 (c) Does not include any of the following:

2 (i) Video programming provided solely as part of, and through, a
3 service that enables users to access content, information, e-mail,
4 messaging or other services that are offered via the public internet.

5 (ii) Direct broadcast satellite service.

6 (iii) Wireless multichannel video programming that is provided by a
7 commercial mobile service provider.

8 29. "Video service network":

9 (a) Means a wireline network, or any component of a wireline
10 network, that is located in this state, constructed in whole or in part
11 in, on, under or over any highway and used to provide video service.

12 (b) Includes a cable system.

13 30. "Video service provider":

14 (a) Means any person that provides or offers to provide video
15 service over a video service network to subscribers in this state.

16 (b) Includes an incumbent cable operator that elected pursuant to
17 sections 9-1412 and 9-1413 to terminate its local license and a
18 multichannel video programming distributor.

19 (c) Does not include a holdover cable operator.

20 Sec. 2. Section 9-1415, Arizona Revised Statutes, is amended to
21 read:

22 9-1415. Authority granted by uniform video service license;
23 conditions and limitations prohibited; providing
24 video service

25 A. Not later than thirty days after the date an applicant files a
26 completed application and affidavit pursuant to section 9-1414, the local
27 government shall issue a uniform video service license to the applicant in
28 the form prescribed by section 9-1411. If the local government does not
29 notify the applicant about the completeness of the uniform video service
30 license agreement within the time period prescribed by section 9-1414,
31 subsection D or issue the agreement within the time period required under
32 this subsection, the agreement shall be considered complete and issued to
33 the applicant in the form submitted.

34 B. The uniform video service license issued to an applicant,
35 including an incumbent cable operator, by a local government is a
36 nonexclusive license granting to the holder of the uniform video service
37 license the authority for the term requested in the application to do all
38 of the following:

39 1. Provide video service in all service areas designated in the
40 application and affidavit filed with the local government.

41 2. Construct and operate a video service network in the highways in
42 each service area in compliance with this chapter and all local laws that
43 ~~are not in conflict or otherwise do not~~ conform to this chapter ~~or~~ AND the
44 purposes and objectives of this chapter.

~~3. Operate and maintain facilities installed in the highways in the service area under a local license pursuant to all of the following:~~

~~(a) Section 9-506, subsections I and J.~~

~~(b) Section 9-584.~~

~~(c) Chapter 5, article 8 of this title and title 11, chapter 13, article 1.~~

C. A local government may not condition or limit a uniform video service license by imposing any obligation or requirement that is not authorized by this chapter, including any of the following:

1. Any office location, institutional network or other build-out, line extension, investment or other requirements relating to the overall scope, extent and timing of infrastructure, facilities or deployment of equipment.

2. Any requirements to pay to any person any application, document, license, service or other fee, tax, charge or assessment that is not authorized by this chapter.

D. A holder of a uniform video service license shall provide video service in accordance with the certifications made by the holder in each application and affidavit that the holder files with a local government pursuant to this article.

Sec. 3. Section 9-1441, Arizona Revised Statutes, is amended to read:

9-1441. Management of highways; local governments; permits or licenses

A. In managing a highway under local laws as prescribed in section 9-1411, subsection C, paragraph 9, a local government may manage the use of the highway, including all of the following:

1. Requiring a video service provider that is constructing, installing, working within, maintaining or repairing facilities in, on, under or over any highway to obtain a construction, encroachment or occupancy permit for the work.

2. Inspecting the construction, installation, maintenance or repair work performed on such facilities.

3. Limiting the installation of new aerial facilities.

B. If a video service provider requests a permit or inspection, the local government shall grant or deny the request within the time frame that the local government has in place under section 9-835 ~~or 11-1605~~.

C. If emergency response work or repair becomes necessary in, on, under or over any highway, a video service provider may begin that work or repair without prior approval from a local government if the video service provider notifies the local government as promptly as reasonably possible after learning that the work or repair is necessary.

1 Sec. 4. Section 9-1442, Arizona Revised Statutes, is amended to
2 read:

3 9-1442. Fees and charges; emergency alert; damage;
4 undergrounding; wireless facilities; definition

5 A. Except the license fee on gross revenue authorized by section
6 9-1443 and transaction privilege taxes as provided in subsection B of this
7 section, a local government may not levy a tax, rent, fee or charge,
8 however denominated, on a video service provider for the use of the
9 highways to provide video service or levy a tax, fee or charge on the
10 privilege of engaging in the business of providing video service in the
11 service area. Taxes, rents, fees and charges include all of the
12 following:

13 1. Access channel support except for in-kind services, goods or
14 payments as provided in subsection C of this section.

15 2. Rental, application, construction, permit, inspection,
16 inconvenience and other fees and charges related to a video service
17 provider's use of the highways, including the use authorized by subsection
18 D of this section except that a local government may impose on a video
19 service provider some or all of the fees and charges described in this
20 paragraph. A video service provider shall offset the fees and charges
21 imposed pursuant to this paragraph against the next license fee payment
22 made pursuant to section 9-1443.

23 B. Any transaction privilege taxes otherwise authorized by local
24 law to be levied on the business of providing video service or in relation
25 to use of the highways to provide video service may be levied on a video
26 service provider if the taxes are levied only on gross revenue and the
27 rate of the taxes is subject to this subsection. This subsection does not
28 authorize the imposition of transaction privilege taxes on interstate
29 telecommunications service. The license fee and any transaction privilege
30 taxes levied on gross revenue constitute a franchise fee within the
31 meaning of the term in 47 United States Code section 542(g). The total of
32 the rates of the license fee and of any transaction privilege taxes on
33 gross revenue levied or assessed by a local government for the privilege
34 of providing video service and related use of the highways to provide
35 video service may not exceed a rate of five percent.

36 C. Subsection A of this section does not prohibit a local
37 government from levying fees and charges on a video service provider or
38 its affiliates pursuant to section 9-584 or pursuant to chapter 5, article
39 8 of this title ~~or title 11, chapter 13, article 1~~ without an offset
40 against license fees.

41 D. A local government may not require a video service provider to
42 provide in-kind goods or services, make in-kind payments, assessments or
43 obligations or pay a fee in addition to the monetary license fee levied or
44 assessed as provided in section 9-1443, except for any of the following:

1 1. A local law may impose and enforce obligations equally and
2 uniformly on all video service providers that are operating within the
3 boundaries of a local government and on all holdover cable operators that
4 hold a local license that remains in effect under section 9-1414,
5 subsection A. Under the local law, a local government:

6 (a) May require all video service providers to provide channel
7 capacity for the video service provider to transmit programming over which
8 the video service provider exercises no editorial control except as
9 authorized by 47 United States Code section 531(e). The channel capacity
10 shall be limited to one of the following:

11 (i) Not more than two channels of public, educational or
12 governmental access programming in the basic service tier of the video
13 service network and not more than two channels of noncommercial
14 governmental programming, at least one of which may be programmed by the
15 federal government, in the digital programming tier of the video service
16 network.

17 (ii) Not more than two lines of access programming with each line
18 of programming carried on up to two standard definition channels and two
19 switched digital high-definition channels.

20 (b) Shall specify the programming and the video service provider
21 may require that the channels regularly display an unobtrusive logo or
22 other suitable identifier of the video service provider, if the local
23 government requires channel capacity pursuant to subdivision (a) of this
24 paragraph.

25 (c) May require all video service providers to incur costs and
26 expenses to provide, maintain and operate facilities and equipment of the
27 video service network, including facilities and equipment for signal
28 carriage, processing, reformatting and interconnection for all of the
29 following:

30 (i) To connect the video service network or cable system, as it may
31 be relocated from time to time, to transmit programming to and from
32 existing locations of public, educational or governmental access
33 facilities and to allow monitoring of access programming at the
34 facilities.

35 (ii) To transmit public, educational and governmental access
36 channels to subscribers with the same prevailing quality, functionality
37 and identification as other channels.

38 (d) May require all video service providers and incumbent cable
39 operators to provide at no initial or recurring charge the basic service
40 tier of video service to one outlet and one receiving device at each
41 building occupied by the local government if the building is not more than
42 two hundred feet from the nearest technically and commercially feasible
43 point of connection on the video service network.

1 2. A local government may retain nonreceiving equipment that it
2 owns without charge for the equipment's use and at the local government's
3 expense, including equipment previously provided by an incumbent cable
4 operator.

5 E. A local law may not impose any obligation on a video service
6 provider under subsection D of this section that is more burdensome than
7 the least burdensome requirement under any local license with a service
8 area within the boundaries of the local government that was in effect on
9 February 1, 2019.

10 F. None of the annual fair market value of any channel capacity
11 provided pursuant to subsection D, paragraph 1, subdivision (a), the
12 annual costs and expenses incurred pursuant to subsection D, paragraph 1,
13 subdivision (c) and the annual fair market value of basic service and line
14 extension provided pursuant to subsection D, paragraph 1, subdivision (d)
15 may be offset against the license fee levied or assessed under this
16 section.

17 G. Notwithstanding subsection A of this section, by a
18 nondiscriminatory local law that imposes and enforces the obligations
19 equally and uniformly on all video service providers operating within the
20 boundaries of a local government, a local government may require that a
21 video service provider bear all of the reasonable costs that are
22 associated with repair and restoration of damage caused to private
23 property or highways by the repair, replacement, installation,
24 construction, maintenance or operation of the video service provider's
25 facilities in the highways and that are imposed on a competitively neutral
26 and nondiscriminatory basis in relation to costs borne by
27 telecommunications corporations under section 9-582, subsection C.

28 H. On application, a local government shall issue to a video
29 service provider or its affiliate a permit to attach allowed Wi-Fi radio
30 equipment to the video service network in the highways within the
31 boundaries of the local government. The permit shall allow installation,
32 operation and maintenance of allowed Wi-Fi radio equipment. A local
33 government may require that all of the allowed Wi-Fi radio equipment at a
34 single location fit within a fifteen-inch cube and be contained entirely
35 within a ground-mounted pedestal or be connected directly to and mounted
36 at the same height as one of the video service provider's aerial
37 horizontal conductors. This subsection does not do any of the following:

38 1. Prohibit a local government from requiring a video service
39 provider to place underground aerial facilities to which allowed Wi-Fi
40 equipment is attached.

41 2. Prohibit the imposition of a tax, rent, fee or charge on revenue
42 from services provided through allowed Wi-Fi radio equipment.

43 3. Affect the authority of a local government to manage the
44 highways within its boundaries or to exercise its police powers, including
45 review and approval of an application before issuing a permit.

1 4. Affect any authority of a political subdivision, including an
2 agricultural improvement district or any other special taxing district,
3 the local government or any other person controlling utility poles in the
4 highways to deny, limit, restrict or determine the terms and conditions
5 for the use of or attachment to the utility poles or attachments to other
6 poles of the political subdivision, local government or other person by a
7 video service provider.

8 I. This section does not prohibit a video service provider from
9 agreeing with a local government to provide in-kind services or goods or
10 make in-kind payments in the service area that are otherwise prohibited by
11 this section if the agreement with the local government is not entered
12 into as a condition of operating in the service area under a uniform video
13 service license issued pursuant to this chapter. The agreement may
14 authorize the video service provider to retain license fees and taxes
15 collected from its subscribers in the amount of any offset to license fees
16 specified in the agreement.

17 J. For the purposes of this section, "allowed Wi-Fi radio
18 equipment" means radio equipment that uses only unlicensed radio spectrum
19 and that enables wireless communication with a communications network for
20 unlicensed services such as Wi-Fi service.

21 Sec. 5. Section 9-1444, Arizona Revised Statutes, is amended to
22 read:

23 9-1444. Ownership of a video service network

24 ~~A. A city or town~~ LOCAL GOVERNMENT may not acquire an ownership
25 interest in a video service network unless the ownership interest is
26 acquired at not less than fair market value.

27 ~~B. Except for the purposes of acting as an intermediary in a~~
28 ~~transfer of a uniform video service license, a county may not own a video~~
29 ~~service network.~~

30 Sec. 6. Section 9-1445, Arizona Revised Statutes, is amended to
31 read:

32 9-1445. Review and audit; bundling discounts; action to
33 recover underpayment or overpayment

34 A. Not more than once every three years, a local government, ~~may~~ on
35 reasonable written notice, MAY audit the business books and records of a
36 video service provider to the extent necessary to ensure payment of
37 license fees pursuant to this chapter. The local government may not audit
38 any period that ends more than three years before the date that the notice
39 of audit is received. Any ~~audits~~ AUDIT of a period of time before
40 issuance of a uniform video service license shall be conducted pursuant to
41 the local laws in effect during the period of time.

42 B. Except as otherwise provided by federal law, if a video service
43 provider offers video service bundled with other services that are not
44 video service for a single discounted price, all of the following apply:

1 1. The method that the video service provider uses to determine
2 gross revenue subject to license fees by allocating the single discounted
3 price among the bundle of video service and nonvideo services shall be
4 reasonable and supported by the video service provider's books and
5 records.

6 2. The local government shall accept as reasonable, for purposes of
7 meeting the video service provider's burden of proof, an allocation based
8 on an objective and verifiable method using the books and records that the
9 video service provider kept in the regular course of business for other
10 purposes, including nontax purposes.

11 3. A video service provider may not use bundled offerings as a
12 means to evade paying license fees.

13 C. The local government and the video service provider shall each
14 pay its own costs and fees relating to each audit performed pursuant to
15 subsection A of this section. If the sum determined to be underpaid
16 exceeds five percent of the total fees that the audit determines should
17 have been paid for the period, the video service provider shall pay the
18 local government's reasonable costs of the audit.

19 D. The rate of interest for both underpayments and overpayments is
20 the federal short-term rate determined pursuant to 26 United States Code
21 section 6621(b), plus three percentage points.

22 E. A person that performs a review and audit under subsection A of
23 this section may not receive compensation that is based, in whole or in
24 part, on either of the following:

25 1. Finding a particular result.

26 2. The amount of any underpayment or overpayment of the license fee
27 that is identified because of the review and audit.

28 F. A complaint by a local government for underpayment of a license
29 fee from a video service provider or by a video service provider for
30 overpayment of a license fee to a local government shall be made pursuant
31 to article 5 of this chapter.

32 G. A complaint for a violation of the license fee obligations under
33 this chapter may not be made unless a written demand by a local government
34 for payment of the license fees or a written demand by a video service
35 provider for refund of license fees is made within four months after the
36 local government or video service provider realizes it has been damaged or
37 knows or reasonably should know of the damage caused by the alleged
38 violation.

39 H. A complaint must be filed pursuant to article 5 of this chapter
40 within two years after the written demand is made pursuant to ~~this~~
41 subsection G OF THIS SECTION but not sooner than four months after the
42 written demand.

1 Sec. 7. Section 9-1451, Arizona Revised Statutes, is amended to
2 read:

3 9-1451. Enforcement; office of administrative hearings; fees;
4 fund

5 A. A local government may file a written complaint against a video
6 service provider and a video service provider may file a written complaint
7 against a local government alleging a violation of this chapter or the
8 uniform video service license agreement. Unless otherwise provided in
9 section 9-1445, subsections F, G and H or this section:

10 1. All complaints must be filed with the office of administrative
11 hearings.

12 2. The complainant must serve a copy of the complaint on the party
13 that is the subject of the complaint by personal delivery or certified
14 mail, return receipt requested, or by any other method reasonably
15 calculated to effect actual notice to the local government's last address
16 of record for the party that is the subject of the complaint.

17 3. The party that is the subject of the complaint may file a
18 response to the complaint with the office of administrative hearings
19 within twenty days after service pursuant to paragraph 2 of this
20 subsection. Responses shall be served pursuant to paragraph 2 of this
21 subsection.

22 B. Before filing a complaint pursuant to this section ~~and~~ BOTH of
23 the following apply:

24 1. The complainant must provide notice of the alleged violation of
25 this chapter to the party that is the subject of the complaint.

26 2. The party that is the subject of the complaint must have a
27 period of not less than twenty days after the date it receives the notice
28 to resolve the alleged violation.

29 C. SUBSECTION B OF THIS SECTION DOES NOT APPLY TO A COMPLAINT MADE
30 IN A WRITTEN DEMAND PURSUANT TO SECTION 9-1445, SUBSECTION G.

31 ~~C.~~ D. A hearing before the office of administrative hearings shall
32 be held if a complaint that complies with this section is filed with the
33 office of administrative hearings. Unless other deadlines are established
34 for a particular complaint, all of the following apply:

35 1. The hearing shall be held within two months after the date that
36 the complaint is filed and service is completed pursuant to subsection A
37 of this section.

38 2. The date scheduled for the hearing may be advanced or delayed on
39 the agreement of the parties or on a showing of good cause.

40 ~~D.~~ E. The office of administrative hearings shall prepare and
41 serve a notice of hearing on all parties at least one month before the
42 hearing that states the time and place of the hearing.

43 ~~E.~~ F. A prehearing conference may be held pursuant to section
44 41-1092.05.

1 ~~F.~~ G. Unless it conflicts with the requirements of this section,
2 the hearing shall be conducted pursuant to section 41-1092.07.

3 ~~G.~~ H. The complainant has the burden of persuasion at a hearing
4 under this section.

5 ~~H.~~ I. The decision of the administrative law judge is the final
6 administrative decision with respect to the complaint. The office of
7 administrative hearings shall serve a copy of the administrative law
8 judge's decision on all parties. The final administrative decision may be
9 appealed to the superior court pursuant to title 12, chapter 7, article 6.
10 ~~Notwithstanding section 12-910,~~ The superior court proceeding shall be a
11 trial de novo.

12 ~~I.~~ J. A party may move for rehearing pursuant to section
13 41-1092.09 and the office of administrative hearings shall rule on the
14 motion. Moving for rehearing or review is not necessary for the party to
15 seek judicial review of the decision of the administrative law judge under
16 subsection ~~H~~ I of this section.

17 ~~J.~~ K. Service is complete on personal service or five days after
18 the date that the office of administrative hearings mails the final
19 administrative decision to each party's last known address of record with
20 the local government.

21 ~~K.~~ L. The office of administrative hearings shall adopt rules
22 pursuant to title 41, chapter 6 to administer hearings under this chapter
23 AND TITLE 11, CHAPTER 14. THE RULES SHALL APPLY UNIFORMLY TO HEARINGS
24 INVOLVING LOCAL GOVERNMENTS AND COUNTIES.

25 ~~L.~~ M. The office of administrative hearings shall establish,
26 administer and collect fees in an amount to be determined by the director
27 of the office of administrative hearings. The director shall deposit,
28 pursuant to sections 35-146 and 35-147, all monies in the video service
29 provider complaint fund established by subsection ~~M~~ N of this section.

30 ~~M.~~ N. The video service provider complaint fund is established
31 consisting of monies collected pursuant to subsection ~~L~~ M of this section
32 AND SECTION 11-1951, SUBSECTION M. The office of administrative hearings
33 shall administer the fund. Monies in the fund are continuously
34 appropriated. The office of administrative hearings shall use the monies
35 in the fund for the purpose of administering the duties specified in this
36 article AND TITLE 11, CHAPTER 14, ARTICLE 5.

37 Sec. 8. Title 11, Arizona Revised Statutes, is amended by adding
38 chapter 14, to read:

39 CHAPTER 14

40 VIDEO SERVICE

41 ARTICLE 1. GENERAL PROVISIONS

42 11-1901. Definitions

43 A. IN THIS CHAPTER, UNLESS THE CONTEXT OTHERWISE REQUIRES:

1 1. "AFFILIATE" MEANS A PERSON THAT DIRECTLY OR INDIRECTLY, THROUGH
2 ONE OR MORE INTERMEDIARIES, CONTROLS, IS CONTROLLED BY OR IS UNDER COMMON
3 CONTROL WITH A VIDEO SERVICE PROVIDER.

4 2. "AGREEMENT" MEANS ANY AGREEMENT OR CONTRACT.

5 3. "BOUNDARIES OF A COUNTY" OR "BOUNDARIES" MEANS ALL OF THE AREA
6 OF THE COUNTY THAT IS NOT WITHIN THE CORPORATE LIMITS OF ANY CITY OR TOWN,
7 INCLUDING UNINCORPORATED TERRITORY THAT IS SURROUNDED ON ALL SIDES BY A
8 COMBINATION OF ONE OR MORE CITIES, TOWNS OR INDIAN RESERVATIONS.

9 4. "CABLE OPERATOR" HAS THE SAME MEANING PRESCRIBED IN 47 UNITED
10 STATES CODE SECTION 522.

11 5. "CABLE SERVICE" HAS THE SAME MEANING PRESCRIBED IN 47 UNITED
12 STATES CODE SECTION 522.

13 6. "CABLE SYSTEM" HAS THE SAME MEANING PRESCRIBED IN 47 UNITED
14 STATES CODE SECTION 522.

15 7. "COMMERCIAL MOBILE SERVICE PROVIDER" MEANS A PERSON THAT
16 PROVIDES COMMERCIAL MOBILE SERVICE AS DEFINED IN 47 UNITED STATES CODE
17 SECTION 332(d) OR COMMERCIAL MOBILE RADIO SERVICE AS DESCRIBED IN 47 CODE
18 OF FEDERAL REGULATIONS SECTION 20.3.

19 8. "DAY" MEANS A CALENDAR DAY, EXCEPT A SATURDAY OR SUNDAY OR A
20 HOLIDAY PRESCRIBED IN SECTION 1-301.

21 9. "GROSS REVENUE":

22 (a) MEANS ALL CASH, CREDITS, PROPERTY OF ANY KIND OR NATURE OR
23 OTHER CONSIDERATION THAT IS RECEIVED DIRECTLY OR INDIRECTLY BY A VIDEO
24 SERVICE PROVIDER, ITS AFFILIATES, OR ANY PERSON, FIRM OR CORPORATION IN
25 WHICH THE VIDEO SERVICE PROVIDER HAS A FINANCIAL INTEREST OR THAT HAS A
26 FINANCIAL INTEREST IN THE VIDEO SERVICE PROVIDER AND THAT IS DERIVED FROM
27 THE VIDEO SERVICE PROVIDER'S OPERATION OF ITS VIDEO SERVICE NETWORK TO
28 PROVIDE VIDEO SERVICE IN THE SERVICE AREA.

29 (b) INCLUDES ALL REVENUE FROM CHARGES FOR VIDEO SERVICE TO
30 SUBSCRIBERS AND ALL CHARGES FOR INSTALLATION, REMOVAL, CONNECTION OR
31 REINSTATEMENT OF EQUIPMENT NECESSARY FOR A SUBSCRIBER TO RECEIVE VIDEO
32 SERVICE AND ANY OTHER RECEIPTS FROM SUBSCRIBERS DERIVED FROM THE VIDEO
33 SERVICE PROVIDER'S OPERATION OF THE VIDEO SERVICE NETWORK TO PROVIDE VIDEO
34 SERVICE, INCLUDING RECEIPTS FROM FORFEITED DEPOSITS, SALE OR RENTAL OF
35 EQUIPMENT TO PROVIDE VIDEO SERVICE, LATE CHARGES, INTEREST AND SALE OF
36 PROGRAM GUIDES.

37 (c) DOES NOT INCLUDE:

38 (i) ANY REVENUE NOT RECEIVED, EVEN IF BILLED, SUCH AS BAD DEBT NET
39 OF ANY RECOVERIES OF BAD DEBT OR ANY REFUNDS, REBATES, CREDITS, ALLOWANCES
40 OR DISCOUNTS TO SUBSCRIBERS TO THE EXTENT THAT THE REFUND, REBATE, CREDIT,
41 ALLOWANCE OR DISCOUNT IS ATTRIBUTED TO VIDEO SERVICE.

42 (ii) REVENUE FROM COMMERCIAL ADVERTISING ON THE VIDEO SERVICE
43 NETWORK, THE USE OR LEASE OF STUDIO FACILITIES OF THE VIDEO SERVICE
44 NETWORK, INTERNET ACCESS SERVICE, THE USE OR LEASE OF ITS FACILITIES
45 LOCATED IN THE HIGHWAYS, THE USE OR LEASE OF LEASED ACCESS CHANNELS OR

1 BANDWIDTH, THE USE OR LEASE OF TOWERS, THE PRODUCTION OF VIDEO PROGRAMMING
2 BY THE VIDEO SERVICE PROVIDER, THE SALE, EXCHANGE, USE OR CABLECAST OF ANY
3 PROGRAMMING BY THE VIDEO SERVICE PROVIDER IN THE SERVICE AREA, SALES TO
4 THE VIDEO SERVICE PROVIDER'S SUBSCRIBERS BY PROGRAMMERS OF HOME SHOPPING
5 SERVICES, REIMBURSEMENTS PAID BY PROGRAMMERS FOR LAUNCH FEES OR MARKETING
6 EXPENSES, LICENSE FEES, TAXES OR OTHER FEES OR CHARGES THAT THE VIDEO
7 SERVICE PROVIDER COLLECTS AND PAYS TO ANY GOVERNMENTAL AUTHORITY, ANY
8 INCREASE IN THE VALUE OF ANY STOCK, SECURITY OR ASSET OR ANY DIVIDENDS OR
9 OTHER DISTRIBUTIONS MADE FROM ANY STOCK OR SECURITIES.

10 10. "HIGHWAY" MEANS ALL ROADS, STREETS AND ALLEYS AND OTHER
11 DEDICATED PUBLIC RIGHTS-OF-WAY THAT ARE OPERATED AND MAINTAINED BY THE
12 COUNTY.

13 11. "HOLDER" MEANS A VIDEO SERVICE PROVIDER THAT HAS BEEN ISSUED A
14 UNIFORM VIDEO SERVICE LICENSE PURSUANT TO THIS CHAPTER.

15 12. "HOLDOVER CABLE OPERATOR" MEANS AN INCUMBENT CABLE OPERATOR
16 THAT ELECTS UNDER SECTIONS 11-1912 AND 11-1913 TO CONTINUE TO OPERATE
17 WITHIN ITS SERVICE AREA PURSUANT TO ITS LOCAL LICENSE.

18 13. "INCUMBENT CABLE OPERATOR" MEANS A CABLE OPERATOR OR OTHER
19 VIDEO SERVICE PROVIDER THAT ON DECEMBER 31, 2019 IS PROVIDING VIDEO
20 SERVICE IN THIS STATE PURSUANT TO A LOCAL LICENSE.

21 14. "INFORMATION SERVICE" HAS THE SAME MEANING PRESCRIBED IN 47
22 UNITED STATES CODE SECTION 153.

23 15. "INTERACTIVE COMPUTER SERVICE" HAS THE SAME MEANING PRESCRIBED
24 IN 47 UNITED STATES CODE SECTION 230(f).

25 16. "LICENSE" MEANS A FRANCHISE AS DEFINED IN 47 UNITED STATES CODE
26 SECTION 522.

27 17. "LICENSE FEE" MEANS A LICENSE FEE IMPOSED BY A COUNTY ON A
28 VIDEO SERVICE PROVIDER FOR USING THE HIGHWAYS TO PROVIDE AND FOR THE
29 PRIVILEGE OF PROVIDING VIDEO SERVICE.

30 18. "LOCAL LAW" MEANS ANY CODE, ORDINANCE, RESOLUTION, REGULATION
31 OR OTHER LAW OF A COUNTY.

32 19. "LOCAL LICENSE" MEANS ANY LICENSE, AGREEMENT, PERMIT OR SIMILAR
33 AUTHORIZATION THAT MEETS ALL OF THE FOLLOWING:

34 (a) ALLOWS A PERSON TO CONSTRUCT OR OPERATE A VIDEO SERVICE NETWORK
35 WITHIN THE BOUNDARIES OF A COUNTY.

36 (b) IS ISSUED, GRANTED, APPROVED, EXTENDED OR RENEWED BY THE COUNTY
37 BEFORE JANUARY 1, 2020 PURSUANT TO THE AUTHORITY OF ANY FEDERAL, STATE OR
38 LOCAL LAW IN EFFECT AT THE TIME OF THE ISSUANCE, GRANT, APPROVAL,
39 EXTENSION OR RENEWAL.

40 (c) IS EFFECTIVE UNDER FEDERAL, STATE OR LOCAL LAW ON DECEMBER 31,
41 2019 FOR THE PERSON TO CONTINUE TO CONSTRUCT OR OPERATE A VIDEO SERVICE
42 NETWORK WITHIN THE BOUNDARIES OF A COUNTY.

43 20. "MULTICHANNEL VIDEO PROGRAMMING DISTRIBUTOR" HAS THE SAME
44 MEANING PRESCRIBED IN 47 UNITED STATES CODE SECTION 522.

1 21. "SERVICE AREA" MEANS THAT PART OF THE BOUNDARIES OF A COUNTY
2 WITHIN WHICH A VIDEO SERVICE PROVIDER IS AUTHORIZED TO PROVIDE VIDEO
3 SERVICE PURSUANT TO A UNIFORM VIDEO SERVICE LICENSE OR A LOCAL LICENSE.

4 22. "SUBSCRIBER" MEANS ANY PERSON IN THIS STATE THAT PURCHASES
5 VIDEO SERVICE. SUBSCRIBER DOES NOT INCLUDE ANY PERSON THAT PURCHASES
6 VIDEO SERVICE FOR RESALE AND THAT, ON RESALE, IS REQUIRED TO PAY A LICENSE
7 FEE PURSUANT TO THIS CHAPTER OR THE TERMS OF A LOCAL LICENSE.

8 23. "TELECOMMUNICATIONS":

9 (a) MEANS THE TRANSMISSION, BETWEEN OR AMONG POINTS SPECIFIED BY
10 THE USER, OF INFORMATION OF THE USER'S CHOOSING, WITHOUT CHANGE IN THE
11 FORM OR CONTENT OF THE INFORMATION SENT AND RECEIVED, REGARDLESS OF THE
12 FACILITIES, EQUIPMENT OR TECHNOLOGY USED.

13 (b) DOES NOT INCLUDE COMMERCIAL MOBILE RADIO SERVICE, PAY PHONE
14 SERVICE, INTERSTATE SERVICE OR CABLE SERVICE.

15 24. "TELECOMMUNICATIONS PROVIDER" MEANS A PERSON THAT IS REQUIRED
16 TO OBTAIN FROM THE CORPORATION COMMISSION A CERTIFICATE OF PUBLIC
17 CONVENIENCE AND NECESSITY TO PROVIDE TELECOMMUNICATIONS SERVICE.

18 25. "TELECOMMUNICATIONS SERVICE" MEANS THE OFFERING OF
19 TELECOMMUNICATIONS FOR A FEE DIRECTLY TO THE PUBLIC, OR TO SUCH USERS AS
20 TO BE EFFECTIVELY AVAILABLE DIRECTLY TO THE PUBLIC, REGARDLESS OF THE
21 EQUIPMENT, FACILITIES OR TECHNOLOGY USED.

22 26. "UNIFORM VIDEO SERVICE LICENSE" MEANS A LICENSE THAT IS ISSUED
23 BY A COUNTY IN THE FORM OF UNIFORM VIDEO SERVICE LICENSE AGREEMENT AS
24 ADOPTED PURSUANT TO SECTION 11-1911.

25 27. "VIDEO SERVICE":

26 (a) MEANS THE PROVISION OF MULTICHANNEL VIDEO PROGRAMMING GENERALLY
27 CONSIDERED COMPARABLE TO VIDEO PROGRAMMING DELIVERED BY A TELEVISION
28 BROADCAST STATION, VIDEO SERVICE OR OTHER DIGITAL TELEVISION SERVICE,
29 WHETHER PROVIDED AS PART OF A TIER, ON DEMAND OR ON A PER-CHANNEL BASIS,
30 WITHOUT REGARD TO THE TECHNOLOGY USED TO DELIVER THE VIDEO SERVICE,
31 INCLUDING INTERNET PROTOCOL TECHNOLOGY OR ANY SUCCESSOR TECHNOLOGY.

32 (b) INCLUDES CABLE SERVICE.

33 (c) DOES NOT INCLUDE ANY OF THE FOLLOWING:

34 (i) VIDEO PROGRAMMING PROVIDED SOLELY AS PART OF, AND THROUGH, A
35 SERVICE THAT ENABLES USERS TO ACCESS CONTENT, INFORMATION, E-MAIL,
36 MESSAGING OR OTHER SERVICES THAT ARE OFFERED VIA THE PUBLIC INTERNET.

37 (ii) DIRECT BROADCAST SATELLITE SERVICE.

38 (iii) WIRELESS MULTICHANNEL VIDEO PROGRAMMING THAT IS PROVIDED BY A
39 COMMERCIAL MOBILE SERVICE PROVIDER.

40 28. "VIDEO SERVICE NETWORK":

41 (a) MEANS A WIRELINE NETWORK, OR ANY COMPONENT OF A WIRELINE
42 NETWORK, THAT IS LOCATED IN THIS STATE, CONSTRUCTED IN WHOLE OR IN PART
43 IN, ON, UNDER OR OVER ANY HIGHWAY AND USED TO PROVIDE VIDEO SERVICE.

44 (b) INCLUDES A CABLE SYSTEM.

1 29. "VIDEO SERVICE PROVIDER":

2 (a) MEANS ANY PERSON THAT PROVIDES OR OFFERS TO PROVIDE VIDEO
3 SERVICE OVER A VIDEO SERVICE NETWORK TO SUBSCRIBERS IN THIS STATE.

4 (b) INCLUDES AN INCUMBENT CABLE OPERATOR THAT ELECTED PURSUANT TO
5 SECTIONS 11-1912 AND 11-1913 TO TERMINATE ITS LOCAL LICENSE AND A
6 MULTICHANNEL VIDEO PROGRAMMING DISTRIBUTOR.

7 (c) DOES NOT INCLUDE A HOLDOVER CABLE OPERATOR.

8 11-1902. State preemption; uniform regulation and licensing

9 A. THE LICENSING OF VIDEO SERVICE PROVIDERS AND THE REGULATION AND
10 USE OF VIDEO SERVICE ARE MATTERS OF STATEWIDE CONCERN. EXCEPT AS PROVIDED
11 IN THIS CHAPTER, THE LICENSING OF VIDEO SERVICE PROVIDERS AND THE
12 REGULATION AND USE OF VIDEO SERVICE ARE NOT SUBJECT TO FURTHER REGULATION
13 BY A COUNTY. THE REGULATION OF VIDEO SERVICE PURSUANT TO THIS CHAPTER,
14 INCLUDING APPLICATION TO THE LOCAL LICENSES OF INCUMBENT CABLE OPERATORS,
15 IS REASONABLE AND NECESSARY TO PROMOTE ALL OF THE FOLLOWING:

16 1. PROVISION OF COMPETITIVE VIDEO, TELECOMMUNICATIONS AND
17 INFORMATION SERVICE THROUGHOUT THIS STATE.

18 2. MORE UNIFORM REGULATION OF COMPETITIVE VIDEO SERVICE THROUGHOUT
19 THIS STATE.

20 3. STREAMLINED LICENSING BY COUNTIES AND MORE UNIFORM TERMS AND
21 CONDITIONS FOR VIDEO SERVICE PROVIDERS THAT USE HIGHWAYS TO PROVIDE VIDEO
22 AND OTHER SERVICES OVER VIDEO SERVICE NETWORKS.

23 4. CONTINUED MANAGEMENT BY COUNTIES OF USE OF THEIR HIGHWAYS WITH
24 REASONABLE BURDENS ON CONSTRUCTION AND MAINTENANCE ACROSS BOUNDARIES FOR
25 VIDEO SERVICE PROVIDERS TO USE HIGHWAYS TO PROVIDE VIDEO AND OTHER
26 SERVICES OVER VIDEO SERVICE NETWORKS.

27 5. CONTINUED LEVYING OF LICENSE FEES BY COUNTIES ON SUBSCRIBER
28 SERVICE REVENUES DERIVED FROM OPERATING VIDEO SERVICE NETWORKS TO PROVIDE
29 VIDEO SERVICE.

30 6. SUPPORT FOR FEDERAL SUBSCRIBER SERVICE STANDARDS.

31 B. TO THE FULLEST EXTENT ALLOWED BY FEDERAL LAW, THIS CHAPTER
32 OCCUPIES THE ENTIRE FIELD OF LICENSING AND REGULATION OF VIDEO SERVICE.

33 C. EXCEPT AS OTHERWISE PROVIDED IN THIS CHAPTER, FROM AND AFTER
34 DECEMBER 31, 2019 THIS CHAPTER PREEMPTS AND LIMITS THE ABILITY OF A COUNTY
35 TO REGULATE OR ENFORCE ALL OF THE FOLLOWING:

36 1. THE APPLICATION OF TITLE 9, CHAPTER 5, ARTICLE 1.1 TO VIDEO
37 SERVICE PROVIDERS.

38 2. ANY LOCAL LAW AND ANY AGREEMENT WITH A COUNTY THAT DOES ANY OF
39 THE FOLLOWING:

40 (a) REQUIRES A PERSON OTHER THAN A HOLDOVER CABLE OPERATOR TO
41 OBTAIN OR HOLD FROM A COUNTY ANY LICENSE, PERMIT OR SIMILAR AUTHORIZATION
42 THAT IS A PREREQUISITE TO PROVIDING VIDEO SERVICE OR TO CONSTRUCTING,
43 MAINTAINING OR USING THE HIGHWAYS TO OPERATE A VIDEO SERVICE NETWORK IN
44 THE HIGHWAYS WITHIN ITS BOUNDARIES.

1 (b) REGULATES THE PROVISION OF VIDEO SERVICE OR THE CONSTRUCTION OR
2 OPERATION OF A VIDEO SERVICE NETWORK IF THE LOCAL LAW DOES NOT CONFORM TO
3 THIS CHAPTER.

4 (c) IMPOSES ON A VIDEO SERVICE PROVIDER ANY REQUIREMENT THAT IS
5 RELATED TO INFRASTRUCTURE, FACILITIES OR DEPLOYMENT OF EQUIPMENT THAT DOES
6 NOT CONFORM TO THIS CHAPTER, INCLUDING OFFICE LOCATION, INSTITUTIONAL
7 NETWORK, BUILD-OUT, LINE EXTENSION, INVESTMENT OR OTHER OPERATIONAL
8 REQUIREMENTS THAT ARE NOT DIRECTLY RELATED TO THE COUNTY'S MANAGEMENT OF
9 DEVELOPMENT, USE AND OCCUPANCY OF THE HIGHWAYS.

10 (d) REQUIRES A VIDEO SERVICE PROVIDER TO OBTAIN A LICENSE OR OTHER
11 AUTHORIZATION FROM THE COUNTY TO PROVIDE TELECOMMUNICATIONS SERVICE,
12 INFORMATION SERVICE, INTERACTIVE COMPUTER SERVICE OR OTHER SERVICE IF THE
13 VIDEO SERVICE PROVIDER USES ITS VIDEO SERVICE NETWORK WITHIN THE
14 BOUNDARIES OF THE COUNTY TO PROVIDE THE SERVICE.

15 (e) REQUIRES A VIDEO SERVICE PROVIDER TO PAY TO LOCATE IN DUCTS OR
16 CONDUITS OR ON POLES OWNED BY THE COUNTY IF THE COUNTY REQUIRES
17 INSTALLATION IN THE DUCTS OR CONDUITS OR ON THE POLES.

18 11-1903. Limited application

19 THIS CHAPTER DOES NOT:

20 1. PREVENT A TELECOMMUNICATIONS PROVIDER FROM EXERCISING ANY RIGHTS
21 OR AUTHORITY THAT THE TELECOMMUNICATIONS PROVIDER HAS AS A PUBLIC UTILITY
22 UNDER FEDERAL OR STATE LAW.

23 2. AFFECT ANY AUTHORITY OF A COUNTY, AN AGRICULTURAL IMPROVEMENT
24 DISTRICT, ANY SPECIAL TAXING DISTRICT OR ANY OTHER PERSON THAT CONTROLS
25 UTILITY POLES ON THE HIGHWAYS TO DENY, LIMIT, RESTRICT OR DETERMINE THE
26 RATES, TERMS AND CONDITIONS FOR THE USE OF OR ATTACHMENT BY A VIDEO
27 SERVICE PROVIDER TO UTILITY OR OTHER POLES OWNED BY THE COUNTY OR OTHER
28 PERSON. FOR THE PURPOSES OF THIS PARAGRAPH, "AUTHORITY OF A COUNTY"
29 INCLUDES POLICE POWERS.

30 3. VEST IN THE CORPORATION COMMISSION ANY AUTHORITY OR JURISDICTION
31 OVER VIDEO SERVICE, VIDEO SERVICE PROVIDERS OR VIDEO SERVICE NETWORKS OR
32 OVER THE RATES, TERMS AND CONDITIONS OF POLE ATTACHMENTS UNDER 47 UNITED
33 STATES CODE SECTION 224.

34 4. AFFECT OR PREEMPT ANY GENERALLY APPLICABLE LOCAL LAWS, INCLUDING
35 A COUNTY'S POLICE POWER, TO MANAGE USE AND OCCUPANCY OF THE HIGHWAYS
36 WITHIN THE COUNTY'S BOUNDARIES OR TO EXERCISE THE COUNTY'S POLICE POWERS
37 IF THE COUNTY APPLIES THE LOCAL LAWS AND EXERCISE OF POLICE POWERS TO ALL
38 USERS OF THE HIGHWAYS IN A NONDISCRIMINATORY MANNER.

39 ARTICLE 2. LOCAL LICENSES

40 11-1911. Counties; uniform video service license agreement;
41 forms; provisions

42 A. FROM AND AFTER DECEMBER 31, 2019, A COUNTY HAS THE EXCLUSIVE
43 AUTHORITY TO ISSUE A UNIFORM VIDEO SERVICE LICENSE TO A PERSON TO PROVIDE
44 VIDEO SERVICE AND TO CONSTRUCT AND OPERATE A VIDEO SERVICE NETWORK IN ANY
45 SERVICE AREA WITHIN ITS BOUNDARIES.

1 B. NOT LATER THAN THE EFFECTIVE DATE OF THIS SECTION, EACH COUNTY
2 SHALL ADOPT A STANDARD FORM OF UNIFORM VIDEO SERVICE LICENSE AGREEMENT FOR
3 VIDEO SERVICE PROVIDERS TO BE USED BY THE COUNTY AND A STANDARD FORM OF
4 APPLICATION AND AFFIDAVIT AS DESCRIBED IN SECTION 11-1914. A COUNTY SHALL
5 PRESCRIBE OTHER FORMS ONLY AS NECESSARY TO IMPLEMENT THIS CHAPTER.

6 C. THE UNIFORM VIDEO SERVICE LICENSE AGREEMENT ADOPTED UNDER
7 SUBSECTION B OF THIS SECTION MUST INCLUDE ALL OF THE FOLLOWING PROVISIONS
8 IN SUBSTANTIALLY THE FOLLOWING FORM AND MAY NOT INCLUDE ANY OTHER
9 PROVISIONS:

10 1. THE NAME OF THE VIDEO SERVICE PROVIDER, ITS TYPE OF ENTITY AND
11 ITS JURISDICTION OF FORMATION.

12 2. THE ADDRESS AND TELEPHONE NUMBER OF THE VIDEO SERVICE PROVIDER'S
13 PRINCIPAL PLACE OF BUSINESS.

14 3. THE NAME AND ADDRESS OF THE VIDEO SERVICE PROVIDER'S PRINCIPAL
15 EXECUTIVE OFFICERS OR GENERAL PARTNERS AND ANY PERSONS AUTHORIZED TO
16 REPRESENT THE VIDEO SERVICE PROVIDER BEFORE THE COUNTY.

17 4. IF THE VIDEO SERVICE PROVIDER IS NOT AN INCUMBENT CABLE
18 OPERATOR, THE DATE ON WHICH THE PROVIDER EXPECTS TO PROVIDE VIDEO SERVICE
19 IN THE AREA IDENTIFIED UNDER PARAGRAPH 5 OF THIS SUBSECTION.

20 5. AN EXACT DESCRIPTION OF THE SERVICE AREA TO BE SERVED, AS
21 IDENTIFIED BY A GEOGRAPHIC INFORMATION SYSTEM DIGITAL BOUNDARY THAT MEETS
22 OR EXCEEDS NATIONAL MAP ACCURACY STANDARDS.

23 6. A REQUIREMENT THAT THE VIDEO SERVICE PROVIDER PAY THE LICENSE
24 FEES REQUIRED UNDER THIS CHAPTER AND ALL OTHER LAWFUL FEES AND CHARGES
25 IMPOSED BY THE COUNTY.

26 7. A REQUIREMENT THAT THE VIDEO SERVICE PROVIDER FILE IN A TIMELY
27 MANNER WITH THE FEDERAL COMMUNICATIONS COMMISSION ALL FORMS REQUIRED BY
28 THAT AGENCY BEFORE OFFERING VIDEO SERVICE IN THE SERVICE AREA, INCLUDING
29 THE FORMS REQUIRED BY 47 CODE OF FEDERAL REGULATIONS SECTION 76.1801.

30 8. A REQUIREMENT THAT THE VIDEO SERVICE PROVIDER AGREES TO COMPLY
31 WITH AND BE SUBJECT TO ALL VALID AND ENFORCEABLE FEDERAL AND STATE LAWS.

32 9. A REQUIREMENT THAT THE VIDEO SERVICE PROVIDER AGREES TO COMPLY
33 WITH ALL GENERALLY APPLICABLE, NONDISCRIMINATORY LOCAL LAWS, INCLUDING
34 HIGHWAY USE, MAPPING, INSURANCE, PERFORMANCE BONDS, SECURITY FUND,
35 INDEMNIFICATION OR SIMILAR REQUIREMENTS THAT APPLY TO THE USE AND
36 OCCUPATION OF ANY HIGHWAY AND THAT CONFORM TO THIS CHAPTER.

37 10. A REQUIREMENT THAT THE VIDEO SERVICE PROVIDER COMPLY WITH THE
38 PUBLIC, EDUCATION AND GOVERNMENT PROGRAMMING REQUIREMENTS OF THIS CHAPTER.

39 11. A REQUIREMENT THAT THE VIDEO SERVICE PROVIDER COMPLY WITH ALL
40 CUSTOMER SERVICE RULES OF THE FEDERAL COMMUNICATIONS COMMISSION UNDER 47
41 CODE OF FEDERAL REGULATIONS SECTION 76.309(c) APPLICABLE TO CABLE
42 OPERATORS.

43 12. A REQUIREMENT THAT THE VIDEO SERVICE PROVIDER COMPLY WITH THE
44 CONSUMER PRIVACY REQUIREMENTS OF 47 UNITED STATES CODE SECTION 551
45 APPLICABLE TO CABLE OPERATORS.

1 13. A GRANT OF AUTHORITY BY THE COUNTY TO PROVIDE VIDEO SERVICE IN
2 THE SERVICE AREA AS DESCRIBED UNDER PARAGRAPH 5 OF THIS SUBSECTION.

3 14. A GRANT OF AUTHORITY BY THE COUNTY TO USE AND OCCUPY THE
4 HIGHWAYS IN THE DELIVERY OF THE VIDEO SERVICE, SUBJECT TO THE LAWS OF THIS
5 STATE AND THE POLICE POWERS OF THE COUNTY.

6 15. THE TERM OF THE UNIFORM VIDEO SERVICE LICENSE.

7 16. A REQUIREMENT THAT THE PARTIES TO THE AGREEMENT ARE SUBJECT TO
8 AND MUST COMPLY WITH THIS CHAPTER.

9 D. EXCEPT AS OTHERWISE PROVIDED IN THIS CHAPTER, FROM AND AFTER
10 DECEMBER 31, 2019 A PERSON MAY NOT ACT AS A VIDEO SERVICE PROVIDER OR
11 CONSTRUCT OR OPERATE A VIDEO SERVICE NETWORK WITHIN THE BOUNDARIES OF A
12 COUNTY WITHOUT FIRST HAVING BEEN ISSUED AND CONTINUING TO HOLD A UNIFORM
13 VIDEO SERVICE LICENSE WITH A SERVICE AREA ENCOMPASSING THE BOUNDARIES.

14 E. A LOCAL LICENSE SHALL REMAIN ENFORCEABLE IN ACCORDANCE WITH ITS
15 TERMS UNTIL TERMINATED UNDER SECTION 11-1912, SUBSECTION B.

16 11-1912. Incumbent cable operator; election on local license;
17 procedure to obtain uniform video service license
18 and terminate local license

19 A. FROM AND AFTER DECEMBER 31, 2019, AN INCUMBENT CABLE OPERATOR
20 MAY ELECT TO DO EITHER OF THE FOLLOWING:

21 1. CONTINUE TO OPERATE WITHIN A SERVICE AREA AS DEFINED IN THE
22 LOCAL LICENSE PURSUANT TO SECTION 11-1913.

23 2. TERMINATE THE INCUMBENT CABLE OPERATOR'S LOCAL LICENSE FOR A
24 SERVICE AREA BY APPLYING FOR AND OBTAINING A UNIFORM VIDEO SERVICE LICENSE
25 PURSUANT TO THIS ARTICLE.

26 B. ON OR BEFORE JULY 1, 2020, TO ELECT TO TERMINATE A LOCAL LICENSE
27 UNDER SUBSECTION A OF THIS SECTION IN THE SAME MANNER AS ANY OTHER VIDEO
28 SERVICE PROVIDER, AN INCUMBENT CABLE OPERATOR SHALL APPLY FOR A UNIFORM
29 VIDEO SERVICE LICENSE THAT INCLUDES ONLY THE SERVICE AREA THAT IS DEFINED
30 IN THE LOCAL LICENSE. IF AN INCUMBENT CABLE OPERATOR OBTAINS A UNIFORM
31 VIDEO SERVICE LICENSE FOR THE SERVICE AREA, BOTH OF THE FOLLOWING APPLY:

32 1. THE APPLICANT'S LOCAL LICENSE IS TERMINATED AS TO THE SERVICE
33 AREA BY OPERATION OF LAW FROM AND AFTER THE DATE THE COUNTY ISSUES THE
34 UNIFORM VIDEO SERVICE LICENSE.

35 2. THE INCUMBENT CABLE OPERATOR SHALL OPERATE WITHIN THE SERVICE
36 AREA DEFINED IN THE LOCAL LICENSE UNLESS THE INCUMBENT CABLE OPERATOR
37 ELECTS UNDER SECTION 11-1914, SUBSECTION C TO APPLY FOR A UNIFORM VIDEO
38 SERVICE LICENSE FOR A SERVICE AREA THAT CONSISTS OF THE BOUNDARIES OF THE
39 COUNTY.

40 11-1913. Incumbent cable operator; procedure to continue
41 operating under local license

42 A. IF AN INCUMBENT CABLE OPERATOR DOES NOT TIMELY ELECT TO
43 TERMINATE A LOCAL LICENSE FOR A SERVICE AREA PURSUANT TO SECTION 11-1912,
44 SUBSECTION B, THE PERSON SHALL CONTINUE TO OPERATE THE CABLE SYSTEM AS A
45 HOLDOVER CABLE OPERATOR WITHIN THE SERVICE AREA DEFINED IN THE LOCAL

1 LICENSE AND SHALL COMPLY WITH THE LOCAL LICENSE FOR AS LONG AS IT REMAINS
2 IN EFFECT FOR THE SERVICE AREA. THE LOCAL LICENSE IS NOT EFFECTIVE FOR
3 THE SERVICE AREA FROM AND AFTER THE DATE THE LOCAL LICENSE EXPIRES BY ITS
4 TERMS. THE COUNTY MAY NOT UNILATERALLY RENEW OR EXTEND THE TERM OF THE
5 LOCAL LICENSE FOR THE SERVICE AREA. THE COUNTY AND THE HOLDOVER CABLE
6 OPERATOR SHALL COMPLY WITH ALL OF THE FOLLOWING, WHICH SHALL CONTINUE TO
7 APPLY TO THE LOCAL LICENSE:

8 1. TITLE 9, CHAPTER 5, ARTICLE 1.1.

9 2. SECTION 9-584.

10 3. TITLE 9, CHAPTER 5, ARTICLE 8.

11 4. CHAPTER 13, ARTICLE 1 OF THIS TITLE.

12 B. TO OPERATE WITHIN A SERVICE AREA FROM AND AFTER THE DATE THE
13 LOCAL LICENSE EXPIRES, THE HOLDOVER CABLE OPERATOR MUST APPLY FOR AND
14 OBTAIN A UNIFORM VIDEO SERVICE LICENSE IN THE SAME MANNER AS ANY OTHER
15 VIDEO SERVICE PROVIDER.

16 C. IF A HOLDOVER CABLE OPERATOR IS ISSUED A UNIFORM VIDEO SERVICE
17 LICENSE WITH A SERVICE AREA THAT INCLUDES THE SERVICE AREA DEFINED UNDER
18 THE LOCAL LICENSE WHILE OPERATING PURSUANT TO THE LOCAL LICENSE UNDER
19 SUBSECTION A OF THIS SECTION, THE UNIFORM VIDEO SERVICE LICENSE DOES NOT
20 BECOME EFFECTIVE UNTIL THE LOCAL LICENSE EXPIRES.

21 D. A HOLDOVER CABLE OPERATOR THAT ELECTS TO APPLY FOR A UNIFORM
22 VIDEO SERVICE LICENSE SHALL DO SO AT LEAST ONE MONTH BEFORE THE LOCAL
23 LICENSE EXPIRES.

24 11-1914. Uniform video service license: application: fees

25 A. TO OBTAIN A UNIFORM VIDEO SERVICE LICENSE, A PERSON SHALL FILE
26 WITH THE CLERK OF THE COUNTY AN APPLICATION AND AFFIDAVIT THAT ARE SIGNED
27 BY ONE OF THE PRINCIPAL EXECUTIVE OFFICERS OR GENERAL PARTNERS OF THE
28 APPLICANT AND THAT COMPLY WITH THIS SECTION.

29 B. THE APPLICATION AND AFFIDAVIT SHALL BE IN THE FORM REQUIRED BY
30 THE COUNTY AND SHALL BE REQUIRED TO CONTAIN ALL OF AND NOT MORE THAN THE
31 FOLLOWING:

32 1. EACH SERVICE AREA IN WHICH THE APPLICANT INTENDS TO PROVIDE
33 VIDEO SERVICE IN THE FORMAT AS DESCRIBED IN SECTION 11-1911, SUBSECTION C.
34 EXCEPT AS PROVIDED IN SECTION 11-1912, SUBSECTION B, PARAGRAPH 2, UNDER A
35 UNIFORM VIDEO SERVICE LICENSE THE BOUNDARIES OF THE COUNTY ARE A SINGLE
36 SERVICE AREA AND THE SERVICE AREA CONSISTS OF ALL OF THE TERRITORY WITHIN
37 THE BOUNDARIES OF THAT COUNTY.

38 2. THE INFORMATION PRESCRIBED BY SECTION 11-1911, SUBSECTION C,
39 PARAGRAPHS 1 THROUGH 4. THE HOLDER SHALL NOTIFY THE COUNTY IN WRITING OF
40 CHANGES TO THIS INFORMATION WITHIN THIRTY DAYS AFTER THE CHANGE OCCURS.

41 3. THE TERM OF THE UNIFORM VIDEO SERVICE LICENSE, WHICH MAY NOT
42 EXCEED TEN YEARS.

43 4. AN AGREEMENT TO PAY ALL LAWFUL FEES AND CHARGES IMPOSED BY THE
44 COUNTY.

1 C. AN INCUMBENT CABLE OPERATOR DESCRIBED IN SECTION 11-1912,
2 SUBSECTION B, PARAGRAPH 2 MAY ELECT TO APPLY FOR A UNIFORM VIDEO SERVICE
3 LICENSE FOR A SERVICE AREA THAT CONSISTS OF THE BOUNDARIES OF A COUNTY.

4 D. IF THE COUNTY DETERMINES THAT THE APPLICATION AND AFFIDAVIT ARE
5 INCOMPLETE OR OTHERWISE DEFICIENT FOR FAILURE TO COMPLY WITH THIS SECTION,
6 THE COUNTY SHALL PROVIDE WRITTEN NOTICE TO THE APPLICANT NOT LATER THAN
7 FIFTEEN DAYS AFTER THE DATE OF FILING OF THE APPLICATION AND AFFIDAVIT.
8 THE WRITTEN NOTICE SHALL DO BOTH OF THE FOLLOWING:

9 1. EXPLAIN THE INCOMPLETENESS OR DEFICIENCY IN DETAIL.
10 2. SPECIFY THE INFORMATION OR OTHER ITEMS THAT ARE NECESSARY UNDER
11 THIS SECTION FOR PROPER COMPLETION OF THE APPLICATION AND AFFIDAVIT.

12 E. THE COUNTY MAY NOT DO ANY OF THE FOLLOWING:

13 1. CHARGE A FEE FOR FILING OR PROCESSING AN APPLICATION, AFFIDAVIT,
14 NOTICE OR OTHER DOCUMENT UNDER THIS CHAPTER.
15 2. VOTE ON OR TAKE OTHER OFFICIAL ACTION REGARDING THE APPLICATION,
16 AFFIDAVIT, NOTICE OR OTHER DOCUMENT.
17 3. REQUIRE THE APPLICANT TO OBTAIN THE APPROVAL OF THE COUNTY
18 REGARDING THE APPLICATION, AFFIDAVIT, NOTICE OR OTHER DOCUMENT.
19 4. REQUIRE THE APPLICANT TO ENTER INTO AN AGREEMENT AS DESCRIBED IN
20 SECTION 11-1942, SUBSECTION I.

21 11-1915. Authority granted by uniform video service license;
22 conditions and limitations prohibited; providing
23 video service

24 A. WITHIN THE TIME FRAME THAT THE COUNTY HAS IN PLACE UNDER SECTION
25 11-1605 BUT NOT LATER THAN FORTY-FIVE DAYS AFTER THE DATE AN APPLICANT
26 FILES A COMPLETED APPLICATION AND AFFIDAVIT PURSUANT TO SECTION 11-1914,
27 THE COUNTY SHALL ISSUE A UNIFORM VIDEO SERVICE LICENSE TO THE APPLICANT IN
28 THE FORM PRESCRIBED BY SECTION 11-1911. IF THE COUNTY DOES NOT NOTIFY THE
29 APPLICANT ABOUT THE COMPLETENESS OF THE UNIFORM VIDEO SERVICE LICENSE
30 AGREEMENT WITHIN THE TIME PERIOD PRESCRIBED BY SECTION 11-1914, SUBSECTION
31 D OR ISSUE THE AGREEMENT WITHIN THE TIME PERIOD REQUIRED UNDER THIS
32 SUBSECTION, THE AGREEMENT SHALL BE CONSIDERED COMPLETE AND ISSUED TO THE
33 APPLICANT IN THE FORM SUBMITTED.

34 B. THE UNIFORM VIDEO SERVICE LICENSE ISSUED TO AN APPLICANT,
35 INCLUDING AN INCUMBENT CABLE OPERATOR, BY A COUNTY IS A NONEXCLUSIVE
36 LICENSE GRANTING TO THE HOLDER OF THE UNIFORM VIDEO SERVICE LICENSE THE
37 AUTHORITY FOR THE TERM REQUESTED IN THE APPLICATION TO DO ALL OF THE
38 FOLLOWING:

39 1. PROVIDE VIDEO SERVICE IN ALL SERVICE AREAS DESIGNATED IN THE
40 APPLICATION AND AFFIDAVIT FILED WITH THE COUNTY.

41 2. CONSTRUCT AND OPERATE A VIDEO SERVICE NETWORK IN THE HIGHWAYS IN
42 EACH SERVICE AREA IN COMPLIANCE WITH THIS CHAPTER AND ALL LOCAL LAWS THAT
43 CONFORM TO THIS CHAPTER AND THE PURPOSES AND OBJECTIVES OF THIS CHAPTER.

1 C. A COUNTY MAY NOT CONDITION OR LIMIT A UNIFORM VIDEO SERVICE
2 LICENSE BY IMPOSING ANY OBLIGATION OR REQUIREMENT THAT IS NOT AUTHORIZED
3 BY THIS CHAPTER, INCLUDING ANY OF THE FOLLOWING:

4 1. ANY OFFICE LOCATION, INSTITUTIONAL NETWORK OR OTHER BUILD-OUT,
5 LINE EXTENSION, INVESTMENT OR OTHER REQUIREMENTS RELATING TO THE OVERALL
6 SCOPE, EXTENT AND TIMING OF INFRASTRUCTURE, FACILITIES OR DEPLOYMENT OF
7 EQUIPMENT.

8 2. ANY REQUIREMENTS TO PAY TO ANY PERSON ANY APPLICATION, DOCUMENT,
9 LICENSE, SERVICE OR OTHER FEE, TAX, CHARGE OR ASSESSMENT THAT IS NOT
10 AUTHORIZED BY THIS CHAPTER.

11 D. A HOLDER OF A UNIFORM VIDEO SERVICE LICENSE SHALL PROVIDE VIDEO
12 SERVICE IN ACCORDANCE WITH THE CERTIFICATIONS MADE BY THE HOLDER IN EACH
13 APPLICATION AND AFFIDAVIT THAT THE HOLDER FILES WITH THE COUNTY PURSUANT
14 TO THIS ARTICLE.

15 11-1916. Amendment of uniform video service license to add
16 service area

17 A. TO ADD ONE OR MORE NEW SERVICE AREAS TO A UNIFORM VIDEO SERVICE
18 LICENSE, THE HOLDER SHALL FILE WITH THE CLERK OF THE COUNTY AN APPLICATION
19 FOR AN AMENDMENT TO THE UNIFORM VIDEO SERVICE LICENSE TO ADD EACH NEW
20 SERVICE AREA.

21 B. THE APPLICATION IS SUBJECT TO THE SAME PROCEDURES, REQUIREMENTS,
22 LIMITATIONS AND TIME PERIODS AS AN APPLICATION FOR ISSUANCE OF A UNIFORM
23 VIDEO SERVICE LICENSE PURSUANT TO SECTIONS 11-1914 AND 11-1915.

24 11-1917. Termination of service

25 A. TO TERMINATE THE AUTHORITY TO PROVIDE VIDEO SERVICE TO AN
26 EXISTING SERVICE AREA AUTHORIZED UNDER THE UNIFORM VIDEO SERVICE LICENSE,
27 THE HOLDER OF THE UNIFORM VIDEO SERVICE LICENSE SHALL FILE WITH THE CLERK
28 OF THE COUNTY WRITTEN NOTICE OF THE TERMINATION.

29 B. THE HOLDER MAY TERMINATE SERVICE ON AND AFTER THE DATE THAT THE
30 HOLDER FILES THE WRITTEN NOTICE WITH THE CLERK OF THE COUNTY.

31 C. THE HOLDER SHALL:

32 1. COMPLY WITH APPLICABLE FEDERAL LAWS, INCLUDING RULES AND
33 REGULATIONS OF THE FEDERAL COMMUNICATIONS COMMISSION.

34 2. GIVE ALL AFFECTED SUBSCRIBERS AND COUNTIES NOTICE AT LEAST
35 NINETY DAYS BEFORE TERMINATION OF SERVICE IN ALL OF A SERVICE AREA THAT
36 CONSISTS OF THE BOUNDARIES OF THE COUNTY.

37 11-1918. Boundary change

38 EACH COUNTY WHOSE BOUNDARIES CHANGE SHALL NOTIFY IN A TIMELY MANNER
39 EACH VIDEO SERVICE PROVIDER THAT OPERATES IN THE BOUNDARIES.

40 11-1919. Transfer of uniform video service license

41 A. EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION OR OTHERWISE
42 REQUIRED BY FEDERAL LAW, INCLUDING RULES AND REGULATIONS OF THE FEDERAL
43 COMMUNICATIONS COMMISSION, A UNIFORM VIDEO SERVICE LICENSE IS FULLY
44 TRANSFERABLE TO ANY PERSON WHETHER THE TRANSFER ARISES THROUGH MERGER,
45 SALE, ASSIGNMENT, RESTRUCTURING, CHANGE OF CONTROL OR OTHER TYPE OF

1 TRANSACTION. A TRANSFER DOES NOT INCLUDE AN ASSIGNMENT OF A UNIFORM VIDEO
2 SERVICE LICENSE FOR THE PURPOSE OF SECURING INDEBTEDNESS. A TRANSFER MAY
3 INCLUDE LESS THAN ALL SERVICE AREAS ASSOCIATED WITH A UNIFORM VIDEO
4 SERVICE LICENSE.

5 B. THE HOLDER SHALL FILE WITH THE CLERK OF THE COUNTY WRITTEN
6 NOTICE OF THE TRANSFER OF THE UNIFORM VIDEO SERVICE LICENSE. ON THE
7 FILING OF NOTICE UNDER THIS SUBSECTION, THE TRANSFEREE BECOMES THE HOLDER.

8 11-1920. Extension

9 A. TO EXTEND THE TERM OF A UNIFORM VIDEO SERVICE LICENSE, THE
10 HOLDER OF THE UNIFORM VIDEO SERVICE LICENSE SHALL FILE WITH THE CLERK OF
11 THE COUNTY AT LEAST ONE MONTH BEFORE THE END OF THE TERM OF THE UNIFORM
12 VIDEO SERVICE LICENSE A NOTICE TO EXTEND THE TERM FOR A SPECIFIED PERIOD
13 NOT TO EXCEED TEN YEARS.

14 B. EFFECTIVE ON THE DATE THE HOLDER FILES THE WRITTEN NOTICE WITH
15 THE CLERK OF THE COUNTY, THE TERM IS EXTENDED FOR THE SPECIFIED PERIOD
16 FROM AND AFTER THE DATE OF THE END OF THE THEN-CURRENT TERM.

17 C. TRANSFERRING, AMENDING OR MODIFYING A UNIFORM VIDEO SERVICE
18 LICENSE UNDER OTHER SECTIONS OF THIS ARTICLE DOES NOT EXTEND THE TERM OF
19 THE UNIFORM VIDEO SERVICE LICENSE.

20 11-1921. Subscriber complaints

21 A. A SUBSCRIBER MAY SUBMIT COMPLAINTS ABOUT VIDEO SERVICE TO ANY OF
22 THE FOLLOWING:

- 23 1. THE COUNTY WHERE THE SUBSCRIBER RESIDES.
- 24 2. THE ATTORNEY GENERAL.
- 25 3. THE FEDERAL COMMUNICATIONS COMMISSION.
- 26 4. OTHER AUTHORITIES AS PROVIDED BY LAW.

27 B. A COUNTY MAY CHOOSE TO MONITOR AND ASSIST SUBSCRIBERS WITH THE
28 SUBSCRIBER SERVICE STANDARDS PURSUANT TO 47 CODE OF FEDERAL REGULATIONS
29 SECTION 76.309(c) OR TO BE IDENTIFIED ON BILLS TO SUBSCRIBERS AS THE LOCAL
30 FRANCHISE AUTHORITY FOR A SERVICE AREA CONSISTENT WITH RULES OF THE
31 FEDERAL COMMUNICATIONS COMMISSION.

32 ARTICLE 3. DUTIES OF VIDEO SERVICE PROVIDERS

33 11-1931. Video service; revocation for nonuse

34 A. NOT LATER THAN TWENTY-FOUR MONTHS AFTER THE DATE THAT A COUNTY
35 ISSUES A UNIFORM VIDEO SERVICE LICENSE PURSUANT TO SECTIONS 11-1914 AND
36 11-1915 OR AN AMENDED UNIFORM VIDEO SERVICE LICENSE PURSUANT TO SECTION
37 11-1916, THE HOLDER OF THE UNIFORM VIDEO SERVICE LICENSE SHALL OFFER AND
38 PROVIDE VIDEO SERVICE TO AT LEAST ONE SUBSCRIBER WITHIN EACH SERVICE AREA
39 AUTHORIZED BY THE UNIFORM VIDEO SERVICE LICENSE OR AMENDED UNIFORM VIDEO
40 SERVICE LICENSE UNLESS THE HOLDER CANNOT MEET THE REQUIREMENT FOR REASONS
41 BEYOND THE HOLDER'S CONTROL.

42 B. IF A HOLDER FAILS TO COMPLY WITH SUBSECTION A OF THIS SECTION, A
43 COUNTY MAY REVOKE THE HOLDER'S UNIFORM VIDEO SERVICE LICENSE FOR AFFECTED
44 SERVICE AREAS.

11-1932. Reports; confidentiality; definition

A. A VIDEO SERVICE PROVIDER THAT IS NOT AN INCUMBENT CABLE OPERATOR AND THAT HOLDS A UNIFORM VIDEO SERVICE LICENSE WITH A SERVICE AREA WITHIN THE BOUNDARIES OF A COUNTY SHALL PREPARE AND SUBMIT TO THE COUNTY A SEMIANNUAL REPORT THAT IDENTIFIES THE LOCATIONS WITHIN THE BOUNDARIES THAT ARE ABLE TO RECEIVE VIDEO SERVICE FROM THE VIDEO SERVICE PROVIDER. THIS REPORTING REQUIREMENT APPLIES UNTIL THE VIDEO SERVICE PROVIDER HAS CONSTRUCTED ALL OF THE FACILITIES THE VIDEO SERVICE PROVIDER INTENDS TO CONSTRUCT WITHIN THE BOUNDARIES OF THE COUNTY.

B. THE VIDEO SERVICE PROVIDER SHALL FILE THE REPORT WITH THE COUNTY NOT LATER THAN TWENTY DAYS AFTER THE LAST DAY OF THE SECOND AND FOURTH CALENDAR QUARTERS OF EACH YEAR.

C. INFORMATION CONTAINED IN A REPORT THAT IS SUBMITTED TO A COUNTY PURSUANT TO THIS SECTION:

1. IS CONFIDENTIAL PROPRIETARY INFORMATION OF THE VIDEO SERVICE PROVIDER.

2. IS NOT A PUBLIC RECORD.

3. MUST BE MANAGED SO THAT ANY CRITICAL INFRASTRUCTURE INFORMATION CONTAINED IN THE REPORT IS PROTECTED AS PROVIDED BY LAW.

4. MAY NOT BE DISCLOSED TO ANY PERSON WHO IS NOT AN OFFICER OR EMPLOYEE OF THE COUNTY UNLESS THE VIDEO SERVICE PROVIDER HAS CONSENTED IN WRITING TO THE DISCLOSURE.

D. FOR THE PURPOSES OF THIS SECTION, "CRITICAL INFRASTRUCTURE INFORMATION" HAS THE SAME MEANING PRESCRIBED IN SECTION 41-1801.

11-1933. Nondiscriminatory manner; compliance with standards and federal law

A. A VIDEO SERVICE PROVIDER SHALL ACTIVATE AND OFFER VIDEO SERVICE IN A NONDISCRIMINATORY MANNER WITHIN EACH SERVICE AREA AND MAY NOT DENY ACCESS TO VIDEO SERVICE TO ANY GROUP OF POTENTIAL RESIDENTIAL SUBSCRIBERS WITHIN A PARTICULAR PART OF A SERVICE AREA BECAUSE OF THE INCOME PROFILE OF THE PERSONS WHO RESIDE IN THAT PART OF THE SERVICE AREA.

B. IN PROVIDING VIDEO SERVICE, A VIDEO SERVICE PROVIDER SHALL COMPLY WITH ALL OF THE FOLLOWING:

1. 47 UNITED STATES CODE SECTION 551.

2. ALL ENGINEERING AND SAFETY CODES APPLICABLE TO THE VIDEO SERVICE PROVIDER'S CONSTRUCTION PRACTICES AND INSTALLATION OF EQUIPMENT.

3. ANY TECHNICAL STANDARDS GOVERNING THE DESIGN, CONSTRUCTION AND OPERATION OF A VIDEO SERVICE NETWORK REQUIRED BY FEDERAL LAW.

4. 47 CODE OF FEDERAL REGULATIONS PART 11, AS ADOPTED AND AS MAY BE AMENDED BY THE FEDERAL COMMUNICATIONS COMMISSION, TO THE EXTENT THOSE PROVISIONS REQUIRE A VIDEO SERVICE PROVIDER TO PARTICIPATE IN THE EMERGENCY ALERT SYSTEM.

5. 47 CODE OF FEDERAL REGULATIONS SECTIONS 76.309, 76.1601, 76.1602, 76.1603, 76.1604, 76.1618, 76.1619, 76.1620, 76.1621 AND 76.1622, AS ADOPTED AND AS MAY BE AMENDED BY THE FEDERAL COMMUNICATIONS COMMISSION,

1 ON STANDARDS GOVERNING THE QUALITY OF VIDEO SERVICE AND SUBSCRIBER
2 SERVICE. A VIDEO SERVICE PROVIDER MAY NOT BE REQUIRED TO COMPLY WITH ANY
3 SUBSCRIBER SERVICE STANDARDS THAT ARE MORE BURDENSOME THAN THOSE SET FORTH
4 IN THIS PARAGRAPH.

5 ARTICLE 4. COUNTIES

6 11-1941. Management of highways; counties; permits or
7 licenses

8 A. IN MANAGING A HIGHWAY UNDER LOCAL LAWS DESCRIBED IN SECTION
9 11-1911, SUBSECTION C, PARAGRAPH 9, A COUNTY MAY MANAGE THE USE OF THE
10 HIGHWAY INCLUDING ALL OF THE FOLLOWING:

11 1. REQUIRING A VIDEO SERVICE PROVIDER THAT IS CONSTRUCTING,
12 INSTALLING, WORKING WITHIN, MAINTAINING OR REPAIRING FACILITIES IN, ON,
13 UNDER OR OVER ANY HIGHWAY TO OBTAIN A CONSTRUCTION, ENCROACHMENT OR
14 OCCUPANCY PERMIT FOR THE WORK.

15 2. INSPECTING THE CONSTRUCTION, INSTALLATION, MAINTENANCE OR REPAIR
16 WORK PERFORMED ON SUCH FACILITIES.

17 3. LIMITING INSTALLATION OF NEW AERIAL FACILITIES.

18 B. IF A VIDEO SERVICE PROVIDER REQUESTS A PERMIT OR INSPECTION, THE
19 COUNTY SHALL GRANT OR DENY THE REQUEST WITHIN THE TIME FRAME THAT THE
20 COUNTY HAS IN PLACE UNDER SECTION 11-1605.

21 C. IF EMERGENCY RESPONSE WORK OR REPAIR BECOMES NECESSARY IN, ON,
22 UNDER OR OVER ANY HIGHWAY, A VIDEO SERVICE PROVIDER MAY BEGIN THAT WORK OR
23 REPAIR WITHOUT PRIOR APPROVAL FROM A COUNTY IF THE VIDEO SERVICE PROVIDER
24 NOTIFIES THE COUNTY AS PROMPTLY AS REASONABLY POSSIBLE AFTER LEARNING THAT
25 THE WORK OR REPAIR IS NECESSARY.

26 11-1942. Fees and charges; emergency alert; damage;
27 undergrounding; wireless facilities; definition

28 A. EXCEPT THE LICENSE FEE ON GROSS REVENUE AUTHORIZED BY SECTION
29 11-1943 AND EXCISE TAXES AS PROVIDED IN SUBSECTION B OF THIS SECTION, A
30 COUNTY MAY NOT LEVY A TAX, RENT, FEE OR CHARGE, HOWEVER DENOMINATED, ON A
31 VIDEO SERVICE PROVIDER FOR THE USE OF THE HIGHWAYS TO PROVIDE VIDEO
32 SERVICE OR LEVY A TAX, FEE OR CHARGE ON THE PRIVILEGE OF ENGAGING IN THE
33 BUSINESS OF PROVIDING VIDEO SERVICE IN THE SERVICE AREA. TAXES, RENTS,
34 FEES AND CHARGES INCLUDE ALL OF THE FOLLOWING:

35 1. ACCESS CHANNEL SUPPORT EXCEPT FOR IN-KIND SERVICES, GOODS OR
36 PAYMENTS AS PROVIDED IN SUBSECTION C OF THIS SECTION.

37 2. RENTAL, APPLICATION, CONSTRUCTION, PERMIT, INSPECTION,
38 INCONVENIENCE AND OTHER FEES AND CHARGES RELATED TO A VIDEO SERVICE
39 PROVIDER'S USE OR OCCUPANCY OF THE HIGHWAYS, INCLUDING THE USE AUTHORIZED
40 BY SUBSECTION D OF THIS SECTION EXCEPT THAT A COUNTY MAY IMPOSE ON A VIDEO
41 SERVICE PROVIDER SOME OR ALL OF THE FEES AND CHARGES DESCRIBED IN THIS
42 PARAGRAPH. A VIDEO SERVICE PROVIDER SHALL OFFSET THE FEES AND CHARGES
43 IMPOSED PURSUANT TO THIS PARAGRAPH AGAINST THE NEXT LICENSE FEE PAYMENT
44 MADE PURSUANT TO SECTION 11-1943.

1 B. ANY EXCISE TAXES OTHERWISE AUTHORIZED BY LOCAL LAW TO BE LEVIED
2 ON THE BUSINESS OF PROVIDING VIDEO SERVICE OR IN RELATION TO USE OF THE
3 HIGHWAYS TO PROVIDE VIDEO SERVICE MAY BE LEVIED ON A VIDEO SERVICE
4 PROVIDER IF THE TAXES ARE LEVIED ONLY ON GROSS REVENUE AND THE RATE OF THE
5 TAXES IS SUBJECT TO THIS SUBSECTION. THIS SUBSECTION DOES NOT AUTHORIZE
6 THE IMPOSITION OF EXCISE TAXES ON INTERSTATE TELECOMMUNICATIONS SERVICE.
7 THE LICENSE FEE AND ANY EXCISE TAXES LEVIED ON GROSS REVENUE CONSTITUTE A
8 FRANCHISE FEE WITHIN THE MEANING OF THE TERM IN 47 UNITED STATES CODE
9 SECTION 542(g). THE TOTAL OF THE RATES OF THE LICENSE FEE AND OF ANY
10 EXCISE TAXES ON GROSS REVENUE LEVIED OR ASSESSED BY A COUNTY FOR THE
11 PRIVILEGE OF PROVIDING VIDEO SERVICE AND RELATED USE OF THE HIGHWAYS TO
12 PROVIDE VIDEO SERVICE MAY NOT EXCEED A RATE OF FIVE PERCENT.

13 C. SUBSECTION A OF THIS SECTION DOES NOT PROHIBIT A COUNTY FROM
14 LEVYING FEES AND CHARGES ON A VIDEO SERVICE PROVIDER OR ITS AFFILIATES
15 PURSUANT TO SECTION 9-584 OR CHAPTER 13, ARTICLE 1 OF THIS TITLE WITHOUT
16 AN OFFSET AGAINST LICENSE FEES.

17 D. A COUNTY MAY NOT REQUIRE A VIDEO SERVICE PROVIDER TO PROVIDE
18 IN-KIND GOODS OR SERVICES, MAKE IN-KIND PAYMENTS, ASSESSMENTS OR
19 OBLIGATIONS OR PAY A FEE IN ADDITION TO THE MONETARY LICENSE FEE LEVIED OR
20 ASSESSED AS PROVIDED IN SECTION 11-1943, EXCEPT FOR ANY OF THE FOLLOWING:

21 1. A LOCAL LAW MAY IMPOSE AND ENFORCE OBLIGATIONS EQUALLY AND
22 UNIFORMLY ON ALL VIDEO SERVICE PROVIDERS THAT ARE OPERATING WITHIN THE
23 BOUNDARIES OF A COUNTY AND ON ALL HOLDOVER CABLE OPERATORS THAT HOLD A
24 LOCAL LICENSE THAT REMAINS IN EFFECT UNDER SECTION 11-1914, SUBSECTION A.
25 UNDER THE LOCAL LAW, A COUNTY:

26 (a) MAY REQUIRE ALL VIDEO SERVICE PROVIDERS TO PROVIDE CHANNEL
27 CAPACITY FOR THE VIDEO SERVICE PROVIDER TO TRANSMIT PROGRAMMING OVER WHICH
28 THE VIDEO SERVICE PROVIDER EXERCISES NO EDITORIAL CONTROL EXCEPT AS
29 AUTHORIZED BY 47 UNITED STATES CODE SECTION 531(e). THE CHANNEL CAPACITY
30 SHALL BE LIMITED TO ONE OF THE FOLLOWING:

31 (i) NOT MORE THAN TWO CHANNELS OF PUBLIC, EDUCATIONAL OR
32 GOVERNMENTAL ACCESS PROGRAMMING IN THE BASIC SERVICE TIER OF THE VIDEO
33 SERVICE NETWORK AND NOT MORE THAN TWO CHANNELS OF NONCOMMERCIAL
34 GOVERNMENTAL PROGRAMMING, AT LEAST ONE OF WHICH MAY BE PROGRAMMED BY THE
35 FEDERAL GOVERNMENT, IN THE DIGITAL PROGRAMMING TIER OF THE VIDEO SERVICE
36 NETWORK.

37 (ii) NOT MORE THAN TWO LINES OF ACCESS PROGRAMMING WITH EACH LINE
38 OF PROGRAMMING CARRIED ON UP TO TWO STANDARD DEFINITION CHANNELS AND TWO
39 SWITCHED DIGITAL HIGH-DEFINITION CHANNELS.

40 (b) SHALL SPECIFY THE PROGRAMMING AND THE VIDEO SERVICE PROVIDER
41 MAY REQUIRE THAT THE CHANNELS REGULARLY DISPLAY AN UNOBTRUSIVE LOGO OR
42 OTHER SUITABLE IDENTIFIER OF THE VIDEO SERVICE PROVIDER, IF THE COUNTY
43 REQUIRES CHANNEL CAPACITY PURSUANT TO SUBDIVISION (a) OF THIS PARAGRAPH.

1 (c) MAY REQUIRE ALL VIDEO SERVICE PROVIDERS TO INCUR COSTS AND
2 EXPENSES TO PROVIDE, MAINTAIN AND OPERATE FACILITIES AND EQUIPMENT OF THE
3 VIDEO SERVICE NETWORK, INCLUDING FACILITIES AND EQUIPMENT FOR SIGNAL
4 CARRIAGE, PROCESSING, REFORMATTING AND INTERCONNECTION FOR ALL OF THE
5 FOLLOWING:

6 (i) TO CONNECT THE VIDEO SERVICE NETWORK OR CABLE SYSTEM, AS IT MAY
7 BE RELOCATED FROM TIME TO TIME, TO TRANSMIT PROGRAMMING TO AND FROM
8 EXISTING LOCATIONS OF PUBLIC, EDUCATIONAL OR GOVERNMENTAL ACCESS
9 FACILITIES AND TO ALLOW MONITORING OF ACCESS PROGRAMMING AT THE
10 FACILITIES.

11 (ii) TO TRANSMIT PUBLIC, EDUCATIONAL AND GOVERNMENTAL ACCESS
12 CHANNELS TO SUBSCRIBERS WITH THE SAME PREVAILING QUALITY, FUNCTIONALITY
13 AND IDENTIFICATION AS OTHER CHANNELS.

14 (d) MAY REQUIRE ALL VIDEO SERVICE PROVIDERS AND INCUMBENT CABLE
15 OPERATORS TO PROVIDE AT NO INITIAL OR RECURRING CHARGE THE BASIC SERVICE
16 TIER OF VIDEO SERVICE TO ONE OUTLET AND ONE RECEIVING DEVICE AT EACH
17 BUILDING OCCUPIED BY THE COUNTY IF THE BUILDING IS NOT MORE THAN TWO
18 HUNDRED FEET FROM THE NEAREST TECHNICALLY AND COMMERCIALY FEASIBLE POINT
19 OF CONNECTION ON THE VIDEO SERVICE NETWORK.

20 2. A COUNTY MAY RETAIN NONRECEIVING EQUIPMENT THAT IT OWNS WITHOUT
21 CHARGE FOR THE EQUIPMENT'S USE AND AT THE COUNTY'S EXPENSE, INCLUDING
22 EQUIPMENT PREVIOUSLY PROVIDED BY AN INCUMBENT CABLE OPERATOR.

23 E. A LOCAL LAW MAY NOT IMPOSE ANY OBLIGATION ON A VIDEO SERVICE
24 PROVIDER UNDER SUBSECTION D OF THIS SECTION THAT IS MORE BURDENSOME THAN
25 THE LEAST BURDENSOME REQUIREMENT UNDER ANY LOCAL LICENSE WITH A SERVICE
26 AREA WITHIN THE BOUNDARIES OF THE COUNTY THAT WAS IN EFFECT ON FEBRUARY 1,
27 2019.

28 F. NONE OF THE ANNUAL FAIR MARKET VALUE OF ANY CHANNEL CAPACITY
29 PROVIDED PURSUANT TO SUBSECTION D, PARAGRAPH 1, SUBDIVISION (a), THE
30 ANNUAL COSTS AND EXPENSES INCURRED PURSUANT TO SUBSECTION D, PARAGRAPH 1,
31 SUBDIVISION (c) AND THE ANNUAL FAIR MARKET VALUE OF BASIC SERVICE AND LINE
32 EXTENSION PROVIDED PURSUANT TO SUBSECTION D, PARAGRAPH 1, SUBDIVISION (d)
33 MAY BE OFFSET AGAINST THE LICENSE FEE LEVIED OR ASSESSED UNDER THIS
34 SECTION.

35 G. NOTWITHSTANDING SUBSECTION A OF THIS SECTION, BY A
36 NONDISCRIMINATORY LOCAL LAW THAT IMPOSES AND ENFORCES THE OBLIGATIONS
37 EQUALLY AND UNIFORMLY ON ALL VIDEO SERVICE PROVIDERS OPERATING WITHIN THE
38 BOUNDARIES OF A COUNTY, A COUNTY MAY REQUIRE THAT A VIDEO SERVICE PROVIDER
39 BEAR ALL OF THE REASONABLE COSTS THAT ARE ASSOCIATED WITH REPAIR AND
40 RESTORATION OF DAMAGE CAUSED TO PRIVATE PROPERTY OR HIGHWAYS BY THE
41 REPAIR, REPLACEMENT, INSTALLATION, CONSTRUCTION, MAINTENANCE OR OPERATION
42 OF THE VIDEO SERVICE PROVIDER'S FACILITIES IN THE HIGHWAYS AND THAT ARE
43 IMPOSED ON A COMPETITIVELY NEUTRAL AND NONDISCRIMINATORY BASIS IN RELATION
44 TO COSTS BORNE BY TELECOMMUNICATIONS CORPORATIONS UNDER SECTION 9-582,
45 SUBSECTION C.

1 H. ON APPLICATION, A COUNTY SHALL ISSUE TO A VIDEO SERVICE PROVIDER
2 OR ITS AFFILIATE A PERMIT TO ATTACH ALLOWED WI-FI RADIO EQUIPMENT TO THE
3 VIDEO SERVICE NETWORK IN THE HIGHWAYS WITHIN THE BOUNDARIES OF THE COUNTY.
4 THE PERMIT SHALL ALLOW INSTALLATION, OPERATION AND MAINTENANCE OF ALLOWED
5 WI-FI RADIO EQUIPMENT. A COUNTY MAY REQUIRE THAT ALL OF THE ALLOWED WI-FI
6 RADIO EQUIPMENT AT A SINGLE LOCATION FIT WITHIN A FIFTEEN-INCH CUBE AND BE
7 CONTAINED ENTIRELY WITHIN A GROUND-MOUNTED PEDESTAL OR BE CONNECTED
8 DIRECTLY TO AND MOUNTED AT THE SAME HEIGHT AS ONE OF THE VIDEO SERVICE
9 PROVIDER'S AERIAL HORIZONTAL CONDUCTORS. THIS SUBSECTION DOES NOT DO ANY
10 OF THE FOLLOWING:

11 1. PROHIBIT A COUNTY FROM REQUIRING A VIDEO SERVICE PROVIDER TO
12 PLACE UNDERGROUND AERIAL FACILITIES TO WHICH ALLOWED WI-FI EQUIPMENT IS
13 ATTACHED.

14 2. PROHIBIT THE IMPOSITION OF A TAX, RENT, FEE OR CHARGE ON REVENUE
15 FROM SERVICES PROVIDED THROUGH ALLOWED WI-FI RADIO EQUIPMENT.

16 3. AFFECT THE AUTHORITY OF A COUNTY TO MANAGE THE HIGHWAYS WITHIN
17 ITS BOUNDARIES OR TO EXERCISE ITS POLICE POWERS, INCLUDING REVIEW AND
18 APPROVAL OF AN APPLICATION BEFORE ISSUING A PERMIT.

19 4. AFFECT ANY AUTHORITY OF A POLITICAL SUBDIVISION, INCLUDING AN
20 AGRICULTURAL IMPROVEMENT DISTRICT OR ANY OTHER SPECIAL TAXING DISTRICT,
21 THE COUNTY OR ANY OTHER PERSON CONTROLLING UTILITY POLES IN THE HIGHWAYS
22 TO DENY, LIMIT, RESTRICT OR DETERMINE THE TERMS AND CONDITIONS FOR THE USE
23 OF OR ATTACHMENT TO THE UTILITY POLES OR ATTACHMENTS TO OTHER POLES OF THE
24 POLITICAL SUBDIVISION, COUNTY OR OTHER PERSON BY A VIDEO SERVICE PROVIDER.

25 I. THIS SECTION DOES NOT PROHIBIT A VIDEO SERVICE PROVIDER FROM
26 AGREEING WITH A COUNTY TO PROVIDE IN-KIND SERVICES OR GOODS OR MAKE
27 IN-KIND PAYMENTS IN THE SERVICE AREA THAT ARE OTHERWISE PROHIBITED BY THIS
28 SECTION IF THE AGREEMENT WITH THE COUNTY IS NOT ENTERED INTO AS A
29 CONDITION OF OPERATING IN THE SERVICE AREA UNDER A UNIFORM VIDEO SERVICE
30 LICENSE ISSUED PURSUANT TO THIS CHAPTER. THE AGREEMENT MAY AUTHORIZE THE
31 VIDEO SERVICE PROVIDER TO RETAIN LICENSE FEES AND TAXES COLLECTED FROM ITS
32 SUBSCRIBERS IN THE AMOUNT OF ANY OFFSET TO LICENSE FEES SPECIFIED IN THE
33 AGREEMENT.

34 J. FOR THE PURPOSES OF THIS SECTION, "ALLOWED WI-FI RADIO
35 EQUIPMENT" MEANS RADIO EQUIPMENT THAT USES ONLY UNLICENSED RADIO SPECTRUM
36 AND THAT ENABLES WIRELESS COMMUNICATION WITH A COMMUNICATIONS NETWORK FOR
37 UNLICENSED SERVICES SUCH AS WI-FI SERVICE.

38 11-1943. License fee; requirements; conditions and
39 limitations; pass through to subscribers

40 A. FOR THE PRIVILEGE OF A VIDEO SERVICE PROVIDER TO OCCUPY OR USE,
41 IN WHOLE OR IN PART, ANY HIGHWAY WITHIN THE BOUNDARIES OF A COUNTY TO
42 PROVIDE VIDEO SERVICE THROUGH A VIDEO SERVICE NETWORK, THE COUNTY MAY
43 REQUIRE A VIDEO SERVICE PROVIDER TO PAY A LICENSE FEE TO THE COUNTY BASED
44 ON THE GROSS REVENUE THAT THE VIDEO SERVICE PROVIDER RECEIVES FROM ITS

1 SUBSCRIBERS LOCATED WITHIN THE BOUNDARIES OF THE COUNTY. THE LICENSE FEE
2 BOTH:

3 1. IS SUBJECT TO THE LIMIT PRESCRIBED BY SECTION 11-1942,
4 SUBSECTION B AND TO OFFSET, INCLUDING AMOUNTS COLLECTED FROM SUBSCRIBERS,
5 AS PRESCRIBED BY SECTION 11-1942, SUBSECTIONS A AND I AND SUBSECTION D OF
6 THIS SECTION.

7 2. SHALL BE DUE NO MORE OFTEN THAN QUARTERLY.

8 B. IF THE COUNTY REQUIRES A LICENSE FEE PURSUANT TO SUBSECTION A OF
9 THIS SECTION, THE COUNTY SHALL ADOPT A LOCAL LAW THAT IMPOSES THE LICENSE
10 FEE EQUALLY AND UNIFORMLY ON ALL OF THE FOLLOWING THAT ARE OPERATING
11 WITHIN THE BOUNDARIES OF THE COUNTY:

12 1. VIDEO SERVICE PROVIDERS.

13 2. HOLDOVER CABLE OPERATORS.

14 C. A VIDEO SERVICE PROVIDER SHALL PAY THE ENTIRE AMOUNT OF THE
15 LICENSE FEE DIRECTLY TO THE COUNTY IN A CHECK, DRAFT OR NOTE OR AUTOMATED
16 CLEARINGHOUSE TRANSACTION THAT IS PAYABLE IN LEGAL TENDER AS DEFINED IN
17 SECTION 43-1021.

18 D. A VIDEO SERVICE PROVIDER MAY DO ALL OF THE FOLLOWING:

19 1. PASS THE LICENSE FEE THROUGH TO AND COLLECT THE LICENSE FEE FROM
20 ITS SUBSCRIBERS WITHIN THE BOUNDARIES OF THE COUNTY, INCLUDING FOR AN
21 INCUMBENT CABLE OPERATOR ANY CHANGE IN LICENSE FEES THAT RESULTS FROM A
22 CHANGE IN THE APPLICABLE DEFINITION OF GROSS REVENUE.

23 2. DESIGNATE THE AMOUNT OF THE LICENSE FEE COLLECTED FROM EACH
24 SUBSCRIBER AS A SEPARATE LINE ITEM ON THE SUBSCRIBER'S BILL.

25 11-1944. Ownership of a video service network

26 EXCEPT FOR THE PURPOSES OF ACTING AS AN INTERMEDIARY IN A TRANSFER
27 OF A UNIFORM VIDEO SERVICE LICENSE, A COUNTY MAY NOT OWN A VIDEO SERVICE
28 NETWORK.

29 11-1945. Review and audit; bundling discounts; action to
30 recover underpayment or overpayment

31 A. NOT MORE THAN ONCE EVERY THREE YEARS, A COUNTY, ON REASONABLE
32 WRITTEN NOTICE, MAY AUDIT THE BUSINESS BOOKS AND RECORDS OF A VIDEO
33 SERVICE PROVIDER TO THE EXTENT NECESSARY TO ENSURE PAYMENT OF LICENSE FEES
34 PURSUANT TO THIS CHAPTER. THE COUNTY MAY NOT AUDIT ANY PERIOD THAT ENDS
35 MORE THAN THREE YEARS BEFORE THE DATE THAT THE NOTICE OF AUDIT IS
36 RECEIVED. ANY AUDIT OF A PERIOD OF TIME BEFORE ISSUANCE OF A UNIFORM
37 VIDEO SERVICE LICENSE SHALL BE CONDUCTED PURSUANT TO THE LOCAL LAWS IN
38 EFFECT DURING THE PERIOD OF TIME.

39 B. EXCEPT AS OTHERWISE PROVIDED BY FEDERAL LAW, IF A VIDEO SERVICE
40 PROVIDER OFFERS VIDEO SERVICE BUNDLED WITH OTHER SERVICES THAT ARE NOT
41 VIDEO SERVICE FOR A SINGLE DISCOUNTED PRICE, ALL OF THE FOLLOWING APPLY:

42 1. THE METHOD THAT THE VIDEO SERVICE PROVIDER USES TO DETERMINE
43 GROSS REVENUE SUBJECT TO LICENSE FEES BY ALLOCATING THE SINGLE DISCOUNTED
44 PRICE AMONG THE BUNDLE OF VIDEO SERVICE AND NONVIDEO SERVICES SHALL BE

1 REASONABLE AND SUPPORTED BY THE VIDEO SERVICE PROVIDER'S BOOKS AND
2 RECORDS.

3 2. THE COUNTY SHALL ACCEPT AS REASONABLE, FOR PURPOSES OF MEETING
4 THE VIDEO SERVICE PROVIDER'S BURDEN OF PROOF, AN ALLOCATION BASED ON AN
5 OBJECTIVE AND VERIFIABLE METHOD USING THE BOOKS AND RECORDS THAT THE VIDEO
6 SERVICE PROVIDER KEPT IN THE REGULAR COURSE OF BUSINESS FOR OTHER
7 PURPOSES, INCLUDING NONTAX PURPOSES.

8 3. A VIDEO SERVICE PROVIDER MAY NOT USE BUNDLED OFFERINGS AS A
9 MEANS TO EVADE PAYING LICENSE FEES.

10 C. THE COUNTY AND THE VIDEO SERVICE PROVIDER SHALL EACH PAY ITS OWN
11 COSTS AND FEES RELATING TO EACH AUDIT PERFORMED PURSUANT TO SUBSECTION A
12 OF THIS SECTION. IF THE SUM DETERMINED TO BE UNDERPAID EXCEEDS FIVE
13 PERCENT OF THE TOTAL FEES THAT THE AUDIT DETERMINES SHOULD HAVE BEEN PAID
14 FOR THE PERIOD, THE VIDEO SERVICE PROVIDER SHALL PAY THE COUNTY'S
15 REASONABLE COSTS OF THE AUDIT.

16 D. THE RATE OF INTEREST FOR BOTH UNDERPAYMENTS AND OVERPAYMENTS IS
17 THE FEDERAL SHORT-TERM RATE, DETERMINED PURSUANT TO 26 UNITED STATES CODE
18 SECTION 6621(b), PLUS THREE PERCENTAGE POINTS.

19 E. A PERSON THAT PERFORMS A REVIEW AND AUDIT UNDER SUBSECTION A OF
20 THIS SECTION MAY NOT RECEIVE COMPENSATION THAT IS BASED, IN WHOLE OR IN
21 PART, ON EITHER OF THE FOLLOWING:

22 1. FINDING A PARTICULAR RESULT.

23 2. THE AMOUNT OF ANY UNDERPAYMENT OR OVERPAYMENT OF THE LICENSE FEE
24 THAT IS IDENTIFIED BECAUSE OF THE REVIEW AND AUDIT.

25 F. A COMPLAINT BY A COUNTY FOR UNDERPAYMENT OF A LICENSE FEE FROM A
26 VIDEO SERVICE PROVIDER OR BY A VIDEO SERVICE PROVIDER FOR OVERPAYMENT OF A
27 LICENSE FEE TO A COUNTY SHALL BE MADE PURSUANT TO ARTICLE 5 OF THIS
28 CHAPTER.

29 G. A COMPLAINT FOR A VIOLATION OF THE LICENSE FEE OBLIGATIONS UNDER
30 THIS CHAPTER MAY NOT BE MADE UNLESS A WRITTEN DEMAND BY A COUNTY FOR
31 PAYMENT OF THE LICENSE FEES OR A WRITTEN DEMAND BY A VIDEO SERVICE
32 PROVIDER FOR REFUND OF LICENSE FEES IS MADE WITHIN FOUR MONTHS AFTER THE
33 COUNTY OR VIDEO SERVICE PROVIDER REALIZES IT HAS BEEN DAMAGED OR KNOWS OR
34 REASONABLY SHOULD KNOW OF THE DAMAGE CAUSED BY THE ALLEGED VIOLATION.

35 H. A COMPLAINT MUST BE FILED PURSUANT TO ARTICLE 5 OF THIS CHAPTER
36 WITHIN TWO YEARS AFTER THE WRITTEN DEMAND IS MADE PURSUANT TO SUBSECTION G
37 OF THIS SECTION BUT NOT SOONER THAN FOUR MONTHS AFTER THE WRITTEN DEMAND.

38 ARTICLE 5. ENFORCEMENT

39 11-1951. Enforcement; office of administrative hearings; fees

40 A. A COUNTY MAY FILE A WRITTEN COMPLAINT AGAINST A VIDEO SERVICE
41 PROVIDER AND A VIDEO SERVICE PROVIDER MAY FILE A WRITTEN COMPLAINT AGAINST
42 A COUNTY ALLEGING A VIOLATION OF THIS CHAPTER OR THE UNIFORM VIDEO SERVICE
43 LICENSE AGREEMENT. UNLESS OTHERWISE PROVIDED IN SECTION 11-1945,
44 SUBSECTIONS F, G AND H OR THIS SECTION:

1 1. ALL COMPLAINTS MUST BE FILED WITH THE OFFICE OF ADMINISTRATIVE
2 HEARINGS.

3 2. THE COMPLAINANT MUST SERVE A COPY OF THE COMPLAINT ON THE PARTY
4 THAT IS THE SUBJECT OF THE COMPLAINT BY PERSONAL DELIVERY OR CERTIFIED
5 MAIL, RETURN RECEIPT REQUESTED, OR BY ANY OTHER METHOD REASONABLY
6 CALCULATED TO EFFECT ACTUAL NOTICE TO THE COUNTY'S LAST ADDRESS OF RECORD
7 FOR THE PARTY THAT IS THE SUBJECT OF THE COMPLAINT.

8 3. THE PARTY THAT IS THE SUBJECT OF THE COMPLAINT MAY FILE A
9 RESPONSE TO THE COMPLAINT WITH THE OFFICE OF ADMINISTRATIVE HEARINGS
10 WITHIN TWENTY DAYS AFTER SERVICE PURSUANT TO PARAGRAPH 2 OF THIS
11 SUBSECTION. RESPONSES SHALL BE SERVED PURSUANT TO PARAGRAPH 2 OF THIS
12 SUBSECTION.

13 B. BEFORE FILING A COMPLAINT PURSUANT TO THIS SECTION BOTH OF THE
14 FOLLOWING APPLY:

15 1. THE COMPLAINANT MUST PROVIDE NOTICE OF THE ALLEGED VIOLATION OF
16 THIS CHAPTER TO THE PARTY THAT IS THE SUBJECT OF THE COMPLAINT.

17 2. THE PARTY THAT IS THE SUBJECT OF THE COMPLAINT MUST HAVE A
18 PERIOD OF NOT LESS THAN TWENTY DAYS AFTER THE DATE IT RECEIVES THE NOTICE
19 TO RESOLVE THE ALLEGED VIOLATION.

20 C. SUBSECTION B OF THIS SECTION DOES NOT APPLY TO A COMPLAINT MADE
21 IN A WRITTEN DEMAND PURSUANT TO SECTION 11-1945, SUBSECTION G.

22 D. A HEARING BEFORE THE OFFICE OF ADMINISTRATIVE HEARINGS SHALL BE
23 HELD IF A COMPLAINT THAT COMPLIES WITH THIS SECTION IS FILED WITH THE
24 OFFICE OF ADMINISTRATIVE HEARINGS. UNLESS OTHER DEADLINES ARE ESTABLISHED
25 FOR A PARTICULAR COMPLAINT, ALL OF THE FOLLOWING APPLY:

26 1. THE HEARING SHALL BE HELD WITHIN TWO MONTHS AFTER THE DATE THAT
27 THE COMPLAINT IS FILED AND SERVICE IS COMPLETED PURSUANT TO SUBSECTION A
28 OF THIS SECTION.

29 2. THE DATE SCHEDULED FOR THE HEARING MAY BE ADVANCED OR DELAYED ON
30 THE AGREEMENT OF THE PARTIES OR ON A SHOWING OF GOOD CAUSE.

31 E. THE OFFICE OF ADMINISTRATIVE HEARINGS SHALL PREPARE AND SERVE A
32 NOTICE OF HEARING ON ALL PARTIES AT LEAST ONE MONTH BEFORE THE HEARING
33 THAT STATES THE TIME AND PLACE OF THE HEARING.

34 F. A PREHEARING CONFERENCE MAY BE HELD PURSUANT TO SECTION
35 41-1092.05.

36 G. UNLESS IT CONFLICTS WITH THE REQUIREMENTS OF THIS SECTION, THE
37 HEARING SHALL BE CONDUCTED PURSUANT TO SECTION 41-1092.07.

38 H. THE COMPLAINANT HAS THE BURDEN OF PERSUASION AT A HEARING UNDER
39 THIS SECTION.

40 I. THE DECISION OF THE ADMINISTRATIVE LAW JUDGE IS THE FINAL
41 ADMINISTRATIVE DECISION WITH RESPECT TO THE COMPLAINT. THE OFFICE OF
42 ADMINISTRATIVE HEARINGS SHALL SERVE A COPY OF THE ADMINISTRATIVE LAW
43 JUDGE'S DECISION ON ALL PARTIES. THE FINAL ADMINISTRATIVE DECISION MAY BE
44 APPEALED TO THE SUPERIOR COURT PURSUANT TO TITLE 12, CHAPTER 7, ARTICLE 6.
45 THE SUPERIOR COURT PROCEEDING SHALL BE A TRIAL DE NOVO.

1 J. A PARTY MAY MOVE FOR REHEARING PURSUANT TO SECTION 41-1092.09,
2 AND THE OFFICE OF ADMINISTRATIVE HEARINGS SHALL RULE ON THE MOTION.
3 MOVING FOR REHEARING OR REVIEW IS NOT NECESSARY FOR THE PARTY TO SEEK
4 JUDICIAL REVIEW OF THE DECISION OF THE ADMINISTRATIVE LAW JUDGE UNDER
5 SUBSECTION I OF THIS SECTION.

6 K. SERVICE IS COMPLETE ON PERSONAL SERVICE OR FIVE DAYS AFTER THE
7 DATE THAT THE OFFICE OF ADMINISTRATIVE HEARINGS MAILES THE FINAL
8 ADMINISTRATIVE DECISION TO EACH PARTY'S LAST KNOWN ADDRESS OF RECORD WITH
9 THE COUNTY.

10 L. THE OFFICE OF ADMINISTRATIVE HEARINGS SHALL ADOPT RULES PURSUANT
11 TO TITLE 41, CHAPTER 6 TO ADMINISTER HEARINGS UNDER THIS CHAPTER AND TITLE
12 9, CHAPTER 13. THE RULES SHALL APPLY UNIFORMLY TO HEARINGS INVOLVING
13 LOCAL GOVERNMENTS AS DEFINED IN SECTION 9-1401 AND COUNTIES.

14 M. THE OFFICE OF ADMINISTRATIVE HEARINGS SHALL ESTABLISH,
15 ADMINISTER AND COLLECT FEES IN AN AMOUNT TO BE DETERMINED BY THE DIRECTOR
16 OF THE OFFICE OF ADMINISTRATIVE HEARINGS. THE DIRECTOR SHALL DEPOSIT,
17 PURSUANT TO SECTIONS 35-146 AND 35-147, ALL MONIES IN THE VIDEO SERVICE
18 PROVIDER COMPLAINT FUND ESTABLISHED BY SECTION 9-1451, SUBSECTION N.

19 11-1952. Statute of limitations; costs and attorney fees;
20 federal subscriber service requirements

21 A. EXCEPT AS PROVIDED IN SECTION 11-1945, SUBSECTIONS F, G AND H, A
22 COMPLAINT UNDER THIS ARTICLE MUST BE FILED WITHIN TWO YEARS AFTER THE
23 COMPLAINANT REALIZES IT HAS BEEN DAMAGED AND KNOWS OR REASONABLY SHOULD
24 KNOW THE CAUSE, SOURCE, ACT, EVENT, INSTRUMENTALITY OR CONDITION THAT
25 CAUSED OR CONTRIBUTED TO THE ALLEGED VIOLATION.

26 B. EACH PARTY TO A DISPUTE UNDER THIS CHAPTER SHALL BEAR ITS OWN
27 ATTORNEY FEES AND COSTS.

28 C. THIS ARTICLE DOES NOT APPLY TO CLAIMS THAT A VIDEO SERVICE
29 PROVIDER HAS FAILED TO MEET SUBSCRIBER SERVICE STANDARDS PRESCRIBED BY
30 SECTION 11-1933, SUBSECTION B, PARAGRAPH 5 OR HAS VIOLATED TITLE 44,
31 CHAPTER 10, ARTICLE 7. CLAIMS OF VIOLATIONS OF FEDERAL SUBSCRIBER SERVICE
32 STANDARDS SHALL BE MADE PURSUANT TO THE PROCEDURE ESTABLISHED UNDER
33 FEDERAL LAW.

34 Sec. 9. Section 41-1092.01, Arizona Revised Statutes, is amended to
35 read:

36 41-1092.01. Office of administrative hearings; director;
37 powers and duties; fund

38 A. An office of administrative hearings is established.

39 B. The governor shall appoint the director pursuant to section
40 38-211. At a minimum, the director shall have the experience necessary
41 for appointment as an administrative law judge. The director also shall
42 possess supervisory, management and administrative skills, as well as
43 knowledge and experience relating to administrative law.

44 C. The director shall:

45 1. Serve as the chief administrative law judge of the office.

1 2. Make and execute the contracts and other instruments that are
2 necessary to perform the director's duties.

3 3. Subject to chapter 4, article 4 of this title, hire employees,
4 including full-time administrative law judges, and contract for special
5 services, including temporary administrative law judges, that are
6 necessary to carry out this article. An administrative law judge employed
7 or contracted by the office shall have graduated from an accredited
8 college of law or shall have at least two years of administrative or
9 managerial experience in the subject matter or agency section the
10 administrative law judge is assigned to in the office.

11 4. Make rules that are necessary to carry out this article,
12 including rules governing ex parte communications in contested cases.

13 5. Submit a report to the governor, speaker of the house of
14 representatives and president of the senate by November 1 of each year
15 describing the activities and accomplishments of the office. The
16 director's annual report shall include a summary of the extent and effect
17 of agencies' utilization of administrative law judges, court reporters and
18 other personnel in proceedings under this article and recommendations for
19 changes or improvements in the administrative procedure act or any
20 agency's practice or policy with respect to the administrative procedure
21 act. [THE DIRECTOR SHALL PROVIDE A COPY OF THE REPORT TO THE SECRETARY OF](#)
22 [STATE.](#)

23 6. Secure, compile and maintain all decisions, opinions or reports
24 of administrative law judges issued pursuant to this article and the
25 reference materials and supporting information that may be appropriate.

26 7. Develop, implement and maintain a program for the continuing
27 training and education of administrative law judges and agencies in regard
28 to their responsibilities under this article. The program shall require
29 that an administrative law judge receive training in the technical and
30 subject matter areas of the sections to which the administrative law judge
31 is assigned.

32 8. Develop, implement and maintain a program of evaluation to aid
33 the director in the evaluation of administrative law judges appointed
34 pursuant to this article that includes comments received from the public.

35 9. Annually report the following to the governor, the president of
36 the senate and the speaker of the house of representatives [AND PROVIDE A](#)
37 [COPY OF THIS REPORT TO THE SECRETARY OF STATE](#) by December 1 for the prior
38 fiscal year:

39 (a) The number of administrative law judge decisions rejected or
40 modified by agency heads.

41 (b) By category, the number and disposition of motions filed
42 pursuant to section 41-1092.07, subsection A to disqualify office
43 administrative law judges for bias, prejudice, personal interest or lack
44 of expertise.

1 (c) By agency, the number and type of violations of section
2 41-1009.

3 10. Schedule hearings pursuant to section 41-1092.05 ~~upon~~ ON the
4 request of an agency or the filing of a notice of appeal pursuant to
5 section 41-1092.03.

6 D. The director shall not require legal representation to appear
7 before an administrative law judge.

8 E. Except as provided in subsection F of this section, all state
9 agencies supported by state general fund sources, unless exempted by this
10 article, and the registrar of contractors shall use the services and
11 personnel of the office to conduct administrative hearings. All other
12 agencies shall contract for services and personnel of the office to
13 conduct administrative hearings.

14 F. An agency head, board or commission that directly conducts an
15 administrative hearing as an administrative law judge is not required to
16 use the services and personnel of the office for that hearing.

17 G. Each state agency, and each political subdivision contracting
18 for office services pursuant to subsection I of this section, shall make
19 its facilities available, as necessary, for use by the office in
20 conducting proceedings pursuant to this article.

21 H. The office shall employ full-time administrative law judges to
22 conduct hearings required by this article or other laws as follows:

23 1. The director shall assign administrative law judges from the
24 office to an agency, on either a temporary or a permanent basis, at
25 supervisory or other levels, to preside over contested cases and
26 appealable agency actions in accordance with the special expertise of the
27 administrative law judge in the subject matter of the agency.

28 2. The director shall establish the subject matter and agency
29 sections within the office that are necessary to carry out this
30 article. Each subject matter and agency section shall provide training in
31 the technical and subject matter areas of the section as prescribed in
32 subsection C, paragraph 7 of this section.

33 I. If the office cannot furnish an office administrative law judge
34 promptly in response to an agency request, the director may contract with
35 qualified individuals to serve as temporary administrative law judges.
36 These temporary administrative law judges are not employees of this state.

37 J. The office may provide administrative law judges on a contract
38 basis to any governmental entity to conduct any hearing not covered by
39 this article. The director may enter into contracts with political
40 subdivisions of this state, and these political subdivisions may contract
41 with the director for the purpose of providing administrative law judges
42 and reporters for administrative proceedings or informal dispute
43 resolution. The contract may define the scope of the administrative law
44 judge's duties. Those duties may include the preparation of findings,
45 conclusions, decisions or recommended decisions or a recommendation for

1 action by the political subdivision. For these services, the director
2 shall request payment for services directly from the political subdivision
3 for which the services are performed, and the director may accept payment
4 on either an advance or reimbursable basis.

5 K. The office shall apply monies received pursuant to subsections E
6 and J of this section to offset its actual costs for providing personnel
7 and services.

8 L. The office shall receive complaints against A COUNTY, a local
9 government AS DEFINED IN SECTION 9-1401 or a video service provider as
10 defined in section 9-1401 OR 11-1901 and shall comply with the duties
11 imposed on the office pursuant to title 9, chapter 13 FOR COMPLAINTS
12 INVOLVING LOCAL GOVERNMENTS AND TITLE 11, CHAPTER 14 FOR COMPLAINTS
13 INVOLVING COUNTIES.

14 Sec. 10. Legislative findings

15 The legislature has determined that it is reasonable and necessary
16 to promote a matter of statewide concern by regulating the licensure and
17 provision of video service to promote all of the following:

18 1. Provision of competitive video, telecommunications and
19 information service throughout this state.

20 2. More uniform regulation of competitive video service throughout
21 the state.

22 3. Streamlined licensing by local governments and counties.

23 4. More uniform terms and conditions for video service providers
24 that use highways to provide video and other services over video service
25 networks.

26 5. Continued highway management by local governments and counties
27 with reasonable burdens on video service providers for construction and
28 maintenance across boundaries.

29 6. Continued levying of license fees by local governments and
30 counties on subscriber service revenues derived from operating video
31 service networks to provide video service.

32 7. Support for federal subscriber service standards.

APPROVED BY THE GOVERNOR APRIL 11, 2019.

FILED IN THE OFFICE OF THE SECRETARY OF STATE APRIL 11, 2019.

State of Arizona
House of Representatives
Fifty-fourth Legislature
First Regular Session
2019

CHAPTER 163

HOUSE BILL 2179

AN ACT

AMENDING SECTIONS 9-461.17, 9-584, 9-591, 11-1801, 13-1801, 13-3709, 13-3712, 16-911, 16-921, 18-502, 26-320, 40-283, 40-341, 40-354, 40-360.24, 40-360.41, 40-491, 41-1954, 42-5063, 42-5064, 42-5069 AND 42-5071, ARIZONA REVISED STATUTES; AMENDING SECTION 42-6004, ARIZONA REVISED STATUTES, AS AMENDED BY LAWS 2018, CHAPTER 17, SECTION 1, CHAPTER 249, SECTION 6 AND CHAPTER 341, SECTION 2; AMENDING SECTION 42-6004, ARIZONA REVISED STATUTES, AS AMENDED BY LAWS 2018, CHAPTER 17, SECTION 1, CHAPTER 249, SECTION 6, CHAPTER 263, SECTION 3 AND CHAPTER 341, SECTION 2; AMENDING SECTIONS 44-1273, 48-620, 48-5107 AND 48-5315, ARIZONA REVISED STATUTES; RELATING TO VIDEO SERVICE PROVIDERS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Section 9-461.17, Arizona Revised Statutes, is amended
3 to read:

4 9-461.17. Telecommunications utility relocation: cost
5 reimbursement; definitions

6 A. To the fullest extent allowed by law, if any construction
7 project in any municipality that is undertaken individually or jointly by
8 an intergovernmental contract and that is funded in whole or in part by
9 voter-approved municipal bond proceeds requires that a telecommunications
10 utility adjust or otherwise relocate the telecommunications utility's
11 facilities, the municipality shall reimburse the telecommunications
12 utility, or cause the telecommunications utility to be reimbursed, for the
13 telecommunications utility's relocation costs incurred on facilities
14 located within the municipal boundaries.

15 B. If the telecommunications utility has existing land rights, the
16 municipality shall provide at the municipality's expense the
17 telecommunications utility with equal land rights in the new location of
18 the relocated facilities. If the telecommunications utility's existing
19 facilities are located in the right-of-way under a permit, the
20 municipality shall provide at the municipality's expense the
21 telecommunications utility with rights in the new location of the
22 relocated facilities equivalent to the telecommunications utility's
23 existing rights under the permit.

24 C. A telecommunications utility shall submit a verified itemized
25 claim to the municipality for reimbursement of relocation costs within one
26 hundred eighty days after each calendar quarter in which a
27 telecommunications utility incurs relocation costs.

28 D. The municipality shall:

29 1. Review each verified itemized claim submitted pursuant to
30 subsection C of this section. The review may include an audit conducted
31 pursuant to standard industry accounting principles.

32 2. Reimburse the telecommunications utility for the relocation
33 costs within ninety days after receipt of the verified itemized claim.

34 3. Reimburse verified itemized claims from all affected
35 telecommunications utilities in the order of receipt.

36 E. The reimbursement limitation for paid claims of relocation costs
37 for telecommunications utility facilities for which there are no existing
38 land rights is not more than two percent of the total project monies. The
39 total OF THE project monies is the total dollar amount of all
40 voter-approved MUNICIPAL bond proceeds that fund a construction project
41 from time to time.

42 F. The total amount of reimbursement paid for claims of relocation
43 costs of all telecommunications utility facilities for which there are no
44 existing land rights may not exceed the reimbursement limitation.

1 G. If a verified itemized claim causes the total amount of all
2 claims for telecommunications utility relocation costs to exceed the
3 reimbursement limitation, that claim shall be reduced so that the total
4 amount of reimbursement paid for all claims for which there are no
5 existing land rights equals the reimbursement limitation.

6 H. If the dollar amount of the reimbursement limitation increases
7 as a result of an increase in total project funds after the previous
8 reimbursement limitation is exhausted, within thirty days after the
9 reimbursement limitation is increased the municipality shall resume
10 processing previously submitted and new verified itemized claims under
11 this section.

12 I. The reimbursement limitation does not apply to any claims for
13 reimbursement of relocation costs for telecommunications utility
14 facilities with existing land rights or any amounts paid by the
15 municipality to provide equivalent land or permit rights. These claims
16 and amounts are excluded from the reimbursement limitation.

17 J. This section does not:

18 1. Apply to a construction project funded in whole or in part with
19 voter-approved municipal bond proceeds if approval of the bonds was
20 referred to the voters, or the initiative petition for the bonds was
21 applied for, before January 1, 2017.

22 2. Prohibit a municipality from complying with other applicable
23 law, or with an agreement, that requires the municipality to reimburse a
24 telecommunications utility for more relocation costs than this section
25 provides.

26 K. For the purposes of this section:

27 1. "Intergovernmental contract" means the joint exercise of powers
28 authorized by title 11, chapter 7, article 3.

29 2. "Municipality" includes a charter city.

30 3. "Relocation costs" means all costs of relocating a
31 telecommunications utility's facilities that the telecommunications
32 utility incurs as a direct result of the construction and operation of a
33 construction project. Relocation costs do not include profit but may
34 include a reasonable allocation of general overhead expenses.

35 4. "Telecommunications utility" means any public service
36 corporation, licensed cable ~~system~~ TELEVISION operator, VIDEO SERVICE
37 PROVIDER, telephone line or telegraph line corporation, agricultural
38 improvement district or other person engaged in the transmission, sale or
39 delivery of telecommunications, telephone, cable television, VIDEO,
40 internet or telegraph service directly to the public or to other users as
41 to be effectively available directly to the public.

1 Sec. 2. Section 9-584, Arizona Revised Statutes, is amended to
2 read:

3 9-584. Microcell equipment in public highways; permits; fees;
4 limitations; definitions

5 A. A political subdivision shall allow the following persons and
6 their affiliates to install, operate and maintain microcell equipment in
7 the public highways that are under the jurisdiction of the political
8 subdivision:

9 1. A telecommunications corporation within the licensed area of a
10 license issued by the political subdivision under this article.

11 2. A telecommunications corporation described in section 9-582,
12 subsection E.

13 3. A cable operator AS DEFINED IN SECTION 9-505 in the area of
14 jurisdiction licensed by the political subdivision under section 9-506.

15 4. A VIDEO SERVICE PROVIDER IN THE SERVICE AREA LICENSED BY THE
16 POLITICAL SUBDIVISION.

17 B. On application a political subdivision shall issue permits for
18 the installation, operation and maintenance of microcell equipment in the
19 public highways within the political subdivision on a competitively
20 neutral and nondiscriminatory basis to all persons specified in subsection
21 A of this section. Only a qualified service provider may use microcell
22 equipment to provide commercial mobile radio service.

23 C. All application fees, permit fees and charges levied by a
24 political subdivision for applications or permits shall be levied on a
25 competitively neutral and nondiscriminatory basis and directly related to
26 the costs incurred by the political subdivision in providing services
27 relating to the granting or administration of applications or permits.
28 These fees and charges also shall be reasonably related in time to the
29 occurrence of the costs.

30 D. A political subdivision may not charge a recurring fee, rent or
31 other charge for use of aerial strand-mounted microcell equipment in
32 public highways within the political subdivision if the political
33 subdivision levies a rent, fee or charge on a person identified in
34 subsection A of this section for the use of the public highways to provide
35 a service. This subsection does not prohibit a political subdivision from
36 charging a competitively neutral and nondiscriminatory rent, fee or charge
37 for the use of utility poles or other poles of the political subdivision.

38 E. Except as the political subdivision agrees in the political
39 subdivision's sole discretion, at each site microcell equipment is limited
40 to:

41 1. Not more than two strand-mounted antennas and radio pairs that
42 are owned by a person specified in subsection A of this section or a
43 qualified service provider and that are used to provide commercial mobile
44 radio service.

1 2. Related devices that are owned by a person specified in
2 subsection A of this section and that are mounted on strand between
3 utility poles, including power supplies, housings, cables and similar
4 supporting furnishings and improvements.

5 F. This section does not:

6 1. Affect any authority of a political subdivision, an agricultural
7 improvement district or any other special taxing district, or any other
8 person controlling utility poles in the public highways to deny, limit,
9 restrict or determine the terms and conditions for use of or attachment to
10 the utility poles or attachments to other poles of the political
11 subdivision, district or other person by a person specified in subsection
12 A of this section.

13 2. Prohibit a political subdivision from imposing competitively
14 neutral and nondiscriminatory requirements for a person identified in
15 subsection A of this section to underground aerial facilities to which
16 microcell equipment is attached.

17 3. Prohibit a political subdivision from imposing a tax, rent, fee
18 or charge on revenue from services provided through microcell equipment.

19 4. Affect any authority of a political subdivision to manage the
20 public highways within the political subdivision's boundaries or to
21 exercise the political subdivision's police powers and land use powers,
22 including review and approval of an application before issuing a permit.

23 5. Affect the application of federal law on processing
24 applications, issuing permits and levying charges for the construction,
25 management, installation, operation, maintenance and control of microcell
26 equipment in the public highways.

27 G. For the purposes of this section:

28 1. "Affiliate" means a person that directly or indirectly, through
29 one or more intermediaries, controls, is controlled by or is under common
30 control with a person specified in subsection A of this section.

31 2. "Microcell equipment" means devices that are connected to the
32 aerial facilities of a person specified in subsection A of this section
33 and that are used solely for transmitting, processing and receiving voice
34 and data wireless telecommunications services. Microcell equipment does
35 not include any ground-based equipment.

36 3. Political subdivision does not include an agricultural
37 improvement district or other special taxing district that controls
38 utility poles or an irrigation district.

39 4. "Qualified service provider" means a person that has all
40 applicable authorizations required to provide commercial mobile radio
41 service using microcell equipment.

42 5. "Utility pole" means a pole or similar structure and attached
43 appurtenances including strand that is designed for telecommunications,
44 cable, data or electric functions.

1 Sec. 3. Section 9-591, Arizona Revised Statutes, is amended to
2 read:

3 9-591. Definitions

4 In this article, unless the context otherwise requires:

5 1. "Antenna" means communications equipment that transmits or
6 receives electromagnetic radio frequency signals and that is used in
7 providing wireless services.

8 2. "Applicable codes" means uniform building, fire, electrical,
9 plumbing or mechanical codes that are adopted by a recognized national
10 code organization or local amendments to those codes that are enacted to
11 address threats of destruction of property or injury to persons and to an
12 extent that is not inconsistent with this article.

13 3. "Applicant" means any person that submits an application and
14 that is a wireless provider.

15 4. "Application" means a request that is submitted by an applicant
16 to an authority for a permit to collocate small wireless facilities or to
17 approve the installation, modification or replacement of a utility pole or
18 wireless support structure.

19 5. "Authority" means any city, town, special district or political
20 subdivision of this state that is authorized to make legislative,
21 quasi-judicial or administrative decisions concerning an application.
22 Authority does not include any state court that has jurisdiction over an
23 authority and does not include a county, special taxing district, or
24 electric cooperative.

25 6. "Authority utility pole" means a utility pole that is owned or
26 operated by an authority and that is in a right-of-way. Authority utility
27 pole does not include a utility pole for electric distribution.

28 7. "Cable operator" has the same meaning prescribed in section
29 9-505 AND INCLUDES A VIDEO SERVICE PROVIDER. Cable operator does not
30 include a special taxing district.

31 8. "Collocate" or "collocation" means to install, mount, maintain,
32 modify, operate or replace wireless facilities on, within or adjacent to a
33 wireless support structure or utility pole.

34 9. "Communications service" means cable service as defined in
35 47 United States Code section 522(6), information service as defined in
36 47 United States Code section 153(24), telecommunications service as
37 defined in 47 United States Code section 153(53) or wireless service.

38 10. "Communications service provider" means a cable operator, a
39 provider of information service as defined in 47 United States Code
40 section 153(24), a telecommunications carrier as defined in 47 United
41 States Code section 153(51) or a wireless services provider.

42 11. "Fee" means a onetime charge.

43 12. "Law" means any federal, state or local law, statute, common
44 law, code, rule, regulation, order or ordinance.

1 13. "Monopole" means a wireless support structure that is not more
2 than forty inches in diameter at the ground level and that has all of the
3 wireless facilities mounted on the pole or contained inside of the pole.

4 14. "Permit" means written permission required by an authority to
5 install, mount, maintain, modify, operate or replace a utility pole or
6 monopole, to collocate a small wireless facility on a utility pole or
7 wireless support structure or to collocate wireless facilities on a
8 monopole.

9 15. "Person" means an individual, corporation, limited liability
10 company, partnership, association, trust or other entity or organization,
11 including an authority.

12 16. "Private easement" means an easement or other real property
13 right that is only for the benefit of the grantor and grantee and the
14 grantor's or grantee's successors and assigns.

15 17. "Rate" means a recurring charge.

16 18. "Right-of-way" means the area on, below or above a public
17 roadway, highway, street, sidewalk, alley or utility easement.
18 Right-of-way does not include a federal interstate highway, a state
19 highway or state route under the jurisdiction of the department of
20 transportation, a private easement, property that is owned by a special
21 taxing district, or a utility easement that does not authorize the
22 deployment sought by the wireless provider.

23 19. "Small wireless facility" means a wireless facility that meets
24 both of the following qualifications:

25 (a) All antennas are located inside an enclosure of not more than
26 six cubic feet in volume or, in the case of an antenna that has exposed
27 elements, the antenna and all of the antenna's exposed elements could fit
28 within an imaginary enclosure of not more than six cubic feet in volume.

29 (b) All other wireless equipment associated with the facility is
30 cumulatively not more than twenty-eight cubic feet in volume, or fifty
31 cubic feet in volume if the equipment was ground mounted before August 9,
32 2017. The following types of associated ancillary equipment are not
33 included in the calculation of equipment volume pursuant to this
34 subdivision:

35 (i) An electric meter.

36 (ii) Concealment elements.

37 (iii) A telecommunications demarcation box.

38 (iv) Grounding equipment.

39 (v) A power transfer switch.

40 (vi) A cutoff switch.

41 (vii) Vertical cable runs for the connection of power and other
42 services.

1 20. "Special taxing district" means a special district formed
2 pursuant to title 48, chapter 11, 12, 17, 18, 19, 20 or 22.

3 21. "Utility pole" means a pole or similar structure that is used
4 in whole or in part for communications services, electric distribution,
5 lighting or traffic signals. Utility pole does not include a monopole.

6 22. "Wireless facility":

7 (a) Means equipment at a fixed location that enables wireless
8 communications between user equipment and a communications network,
9 including both of the following:

10 (i) Equipment associated with wireless communications.

11 (ii) Radio transceivers, antennas, coaxial or fiber-optic cables,
12 regular and backup power supplies and comparable equipment, regardless of
13 technological configuration.

14 (b) Includes small wireless facilities.

15 (c) Does not include the structure or improvements on, under or
16 within which the equipment is collocated, wireline backhaul facilities,
17 coaxial or fiber-optic cable that is between wireless support structures
18 or utility poles or coaxial or fiber-optic cable that is otherwise not
19 immediately adjacent to, or directly associated with, an antenna.

20 (d) Does not include Wi-Fi radio equipment described in section
21 9-506, subsection I or microcell equipment described in section 9-584,
22 subsection E.

23 23. "Wireless infrastructure provider" means any person that is
24 authorized to provide telecommunications service in this state and that
25 builds or installs wireless communications transmission equipment,
26 wireless facilities, utility poles or monopoles but that is not a wireless
27 services provider. Wireless infrastructure provider does not include a
28 special taxing district.

29 24. "Wireless provider" means a cable operator, wireless
30 infrastructure provider or wireless services provider.

31 25. "Wireless services" means any services that are provided to the
32 public and that use licensed or unlicensed spectrum, whether at a fixed
33 location or mobile, using wireless facilities.

34 26. "Wireless services provider" means a person that provides
35 wireless services. Wireless services provider does not include a special
36 taxing district.

37 27. "Wireless support structure":

38 (a) Means:

39 (i) A freestanding structure, such as a monopole.

40 (ii) A tower, either guyed or self-supporting.

41 (iii) A sign or billboard.

42 (iv) Any other existing or proposed structure designed to support
43 or capable of supporting small wireless facilities.

44 (b) Does not include a utility pole.

1 Sec. 4. Section 11-1801, Arizona Revised Statutes, is amended to
2 read:

3 11-1801. Definitions

4 In this article, unless the context otherwise requires:

5 1. "Antenna" means communications equipment that transmits or
6 receives electromagnetic radio frequency signals and that is used in
7 providing wireless services.

8 2. "Applicable codes" means uniform building, fire, electrical,
9 plumbing or mechanical codes that are adopted by a recognized national
10 code organization or local amendments to those codes that are enacted to
11 address threats of destruction of property or injury to persons and to an
12 extent that is not inconsistent with this article.

13 3. "Applicant" means any person that submits an application and
14 that is a wireless provider.

15 4. "Application" means a request that is submitted by an applicant
16 to a county on a form provided by the county for a permit to collocate
17 small wireless facilities or to approve the installation, modification or
18 replacement of a utility pole.

19 5. "Cable operator" has the same meaning prescribed in section
20 9-505 AND INCLUDES A VIDEO SERVICE PROVIDER. Cable operator does not
21 include a special taxing district.

22 6. "Collocate" or "collocation" means to install, mount, maintain,
23 modify, operate or replace wireless facilities on, within or adjacent to a
24 wireless support structure or utility pole.

25 7. "Communications service" means cable service as defined in
26 47 United States Code section 522(6), information service as defined in
27 47 United States Code section 153(24), telecommunications service as
28 defined in 47 United States Code section 153(53) or wireless service.

29 8. "Communications service provider" means a cable operator, a
30 provider of information service as defined in 47 United States Code
31 section 153(24), a telecommunications carrier as defined in 47 United
32 States Code section 153(51) or a wireless services provider.

33 9. "County utility pole" means a utility pole that is owned or
34 operated by a county and that is in a right-of-way.

35 10. "Fee" means a onetime charge to process an application and
36 inspect any work performed by an applicant pursuant to a permit issued by
37 the county.

38 11. "Law" means any federal, state or local law, statute, common
39 law, code, rule, regulation, order or ordinance.

40 12. "Permit" means written permission issued by a county to
41 install, mount, maintain, modify, operate or replace a utility pole or to
42 collocate a small wireless facility on a utility pole or wireless support
43 structure.

1 13. "Person" means an individual, corporation, limited liability
2 company, partnership, association, trust or other entity or organization,
3 including a county.

4 14. "Private easement" means an easement or other real property
5 right that is only for the benefit of the grantor and grantee and the
6 grantor's or grantee's successors and assigns.

7 15. "Rate" means a onetime charge for the granting of a right to
8 use a portion of a right-of-way as specified in a permit or to collocate a
9 small wireless facility on or adjacent to a utility pole or to install,
10 modify or replace a utility pole as specified in a permit.

11 16. "Right-of-way" means the area on, below or above a county
12 roadway, highway, street, sidewalk, alley or utility easement.
13 Right-of-way does not include a federal interstate highway, a state
14 highway or state route under the jurisdiction of the department of
15 transportation, a private easement, property that is owned by a special
16 taxing district, or a utility easement that does not authorize the
17 deployment sought by the wireless provider.

18 17. "Small wireless facility" means a wireless facility that meets
19 both of the following qualifications:

20 (a) All antennas are located inside an enclosure of not more than
21 six cubic feet in volume or, in the case of an antenna that has exposed
22 elements, the antenna and all of the antenna's exposed elements could fit
23 within an imaginary enclosure of not more than six cubic feet in volume.

24 (b) All other wireless equipment associated with the facility is
25 cumulatively not more than twenty-eight cubic feet in volume, or fifty
26 cubic feet in volume if the equipment was ground mounted before August 9,
27 2017. The following types of associated ancillary equipment are not
28 included in the calculation of equipment volume pursuant to this
29 subdivision:

30 (i) An electric meter.

31 (ii) Concealment elements.

32 (iii) A telecommunications demarcation box.

33 (iv) Grounding equipment.

34 (v) A power transfer switch.

35 (vi) A cutoff switch.

36 (vii) Vertical cable runs for the connection of power and other
37 services.

38 18. "Special taxing district" means a special district formed
39 pursuant to title 48, chapter 11, 12, 17, 18, 19, 20 or 22.

40 19. "Utility pole" means a pole or similar structure that is used
41 in whole or in part for communications services, electric distribution,
42 lighting or traffic signals or a similar function.

43 20. "Wireless facility":

1 (a) Means equipment at a fixed location that enables wireless
2 communications between user equipment and a communications network,
3 including both of the following:

4 (i) Equipment associated with wireless communications.

5 (ii) Radio transceivers, antennas, coaxial or fiber-optic cables,
6 regular and backup power supplies and comparable equipment, regardless of
7 technological configuration.

8 (b) Includes small wireless facilities.

9 (c) Does not include the structure or improvements on, under or
10 within which the equipment is collocated, wireline backhaul facilities,
11 coaxial or fiber-optic cable that is between wireless support structures
12 or utility poles or coaxial or fiber-optic cable that is otherwise not
13 immediately adjacent to, or directly associated with, an antenna.

14 (d) Does not include Wi-Fi radio equipment described in section
15 9-506, subsection I or microcell equipment described in section 9-584,
16 subsection E.

17 21. "Wireless infrastructure provider" means any person that is
18 authorized to provide telecommunications service in this state and that
19 builds or installs wireless communications transmission equipment,
20 wireless facilities or utility poles but that is not a wireless services
21 provider. Wireless infrastructure provider does not include a special
22 taxing district.

23 22. "Wireless provider" means a cable operator, wireless
24 infrastructure provider or wireless services provider.

25 23. "Wireless services" means any services that are provided to the
26 public and that use licensed or unlicensed spectrum, whether at a fixed
27 location or mobile, using wireless facilities.

28 24. "Wireless services provider" means a person that provides
29 wireless services. Wireless services provider does not include a special
30 taxing district.

31 25. "Wireless support structure":

32 (a) Means:

33 (i) A freestanding structure.

34 (ii) A tower, either guyed or self-supporting.

35 (iii) Any other existing or proposed structure designed to support
36 or capable of supporting small wireless facilities.

37 (b) Does not include a utility pole.

38 Sec. 5. Section 13-1801, Arizona Revised Statutes, is amended to
39 read:

40 13-1801. Definitions

41 A. In this chapter, unless the context otherwise requires:

42 1. "Check" means any check, draft or other negotiable or
43 nonnegotiable instrument of any kind.

1 2. "Control" or "exercise control" means to act so as to exclude
2 others from using their property except on the defendant's own terms.

3 3. "Credit" means an express agreement with the drawee for the
4 payment of a check.

5 4. "Deprive" means to withhold the property interest of another
6 either permanently or for so long a time period that a substantial portion
7 of its economic value or usefulness or enjoyment is lost, to withhold with
8 the intent to restore it only on payment of any reward or other
9 compensation or to transfer or dispose of it so that it is unlikely to be
10 recovered.

11 5. "Draw" means making, drawing, uttering, preparing, writing or
12 delivering a check.

13 6. "Funds" means money or credit.

14 7. "Issue" means to deliver or cause to be delivered a check to a
15 person who thereby acquires a right against the drawer with respect to the
16 check. A person who draws a check with the intent that it be so delivered
17 is deemed to have issued it if the delivery occurs.

18 8. "Material misrepresentation" means a pretense, promise,
19 representation or statement of present, past or future fact that is
20 fraudulent and that, when used or communicated, is instrumental in causing
21 the wrongful control or transfer of property or services. The pretense
22 may be verbal or it may be a physical act.

23 9. "Means of transportation" means any vehicle.

24 10. "Obtain" means to bring about or to receive the transfer of any
25 interest in property, whether to a defendant or to another, or to secure
26 the performance of a service or the possession of a trade secret.

27 11. "Pass" means, for a payee, holder or bearer of a check that
28 previously has been or purports to have been drawn and issued by another,
29 to deliver a check, for a purpose other than collection, to a third person
30 who by delivery acquires a right with respect to the check.

31 12. "Property" means any thing of value, tangible or intangible,
32 including trade secrets.

33 13. "Property of another" means property in which any person other
34 than the defendant has an interest on which the defendant is not
35 privileged to infringe, including property in which the defendant also has
36 an interest, notwithstanding the fact that the other person might be
37 precluded from civil recovery because the property was used in an unlawful
38 transaction or was subject to forfeiture as contraband. Property in
39 possession of the defendant is not deemed property of another person who
40 has only a security interest in the property, even if legal title is in
41 the creditor pursuant to a security agreement.

42 14. "Services" includes labor, professional services,
43 transportation, cable ~~television~~ SERVICE AND VIDEO SERVICE, computer or
44 communication services, gas or electricity services, accommodation in

1 hotels, restaurants or leased premises or elsewhere, admission to
2 exhibitions and use of vehicles or other movable property.

3 15. "Value" means the fair market value of the property or services
4 at the time of the theft. The value of ferrous metal, **AS DEFINED IN**
5 **SECTION 44-1641**, or nonferrous metal, ~~as defined in section 44-1641~~, is
6 the average fair market value of the metal in the local area together with
7 the repair or replacement value of any property from which the metal was
8 removed at the time of the theft. Written instruments that do not have a
9 readily ascertained market value have as their value either the face
10 amount of indebtedness less the portion satisfied or the amount of
11 economic loss involved in deprivation of the instrument, whichever is
12 greater. When property has an undeterminable value the trier of fact
13 shall determine its value and, in reaching its decision, may consider all
14 relevant evidence, including evidence of the property's value to its
15 owner.

16 B. In determining the classification of the offense, the state may
17 aggregate in the indictment or information amounts taken in thefts
18 committed pursuant to one scheme or course of conduct, whether the amounts
19 were taken from one or several persons.

20 Sec. 6. Section 13-3709, Arizona Revised Statutes, is amended to
21 read:

22 **13-3709. Obtaining cable television and video services**
23 **fraudulently; manufacturing, distributing and**
24 **selling unauthorized decoding devices;**
25 **classification; definition**

26 A. Any person who with the intent to defraud another of any part of
27 the lawful charge for services that are provided over or by a licensed
28 cable television system as defined in section 9-505, ~~OR A LICENSED VIDEO~~
29 **SERVICE NETWORK** makes any unauthorized connection, whether physically,
30 electrically, acoustically, inductively or otherwise, or attaches any
31 unauthorized device or devices to any cable, wire, microwave or other
32 component of a licensed cable television system **OR LICENSED VIDEO SERVICE**
33 **NETWORK**, to a television set or to any other instrument that is authorized
34 to be attached to a **LICENSED** cable television system **OR LICENSED VIDEO**
35 **SERVICE NETWORK** is guilty of a class 2 misdemeanor.

36 B. Any person who manufactures, distributes, sells, rents, lends,
37 offers or advertises for sale, rental or use any device that the person
38 intends to be used by another person to obtain services that are provided
39 over or by a licensed cable television system **OR A LICENSED VIDEO SERVICE**
40 **NETWORK** without payment of the charge for those services is guilty of a
41 class 6 felony.

42 C. For the purposes of subsection B of this section it is a
43 rebuttable presumption that the person intended that the device would be
44 used by another person to obtain services that are provided over or by a
45 licensed cable television system **OR A LICENSED VIDEO SERVICE NETWORK**

1 without payment of the charge for those services if, while advertising,
2 selling, renting or lending the device, the person states that the device
3 will enable the person who receives the device to obtain cable television,
4 VIDEO or other services without payment of the charge for those services.

5 D. For the purposes of subsection B of this section, it is a
6 separate violation for each individual device that is manufactured,
7 distributed, sold, rented, lent, offered or advertised for sale, rental or
8 use in violation of subsection B of this section.

9 E. A person whose business or property is injured arising out of a
10 violation of this section may bring an action in superior court to recover
11 damages or for an injunction, or both. The successful party to the action
12 may recover reasonable attorney fees.

13 F. ~~As used in~~ FOR THE PURPOSES OF this section, "device" includes
14 any component or combination of components capable of converting a
15 scrambled, ENCRYPTED or ~~coded~~ ENCODED cable television OR VIDEO SERVICE
16 signal to a signal usable on a standard television receiver.

17 Sec. 7. Section 13-3712, Arizona Revised Statutes, is amended to
18 read:

19 13-3712. Interruption of or injury to cable television and
20 video systems; classification

21 Any person who, without the consent of the owner, knowingly tampers
22 with, removes or injures any cable, wire, microwave or other component of
23 a licensed cable television system as defined in section 9-505 OR LICENSED
24 VIDEO SERVICE NETWORK or knowingly interrupts the service of ~~such a~~ THE
25 licensed cable television system OR LICENSED VIDEO SERVICE NETWORK without
26 the consent of the owner is guilty of a class 2 misdemeanor.

27 Sec. 8. Section 16-911, Arizona Revised Statutes, is amended to
28 read:

29 16-911. Exemption from definition of contribution

30 A. A person may make any contribution not otherwise prohibited by
31 law.

32 B. The following are not contributions:

33 1. The value of an individual's volunteer services or expenses that
34 are provided without compensation or reimbursement, including the
35 individual's:

36 (a) Travel expenses.

37 (b) Use of real or personal property.

38 (c) Cost of invitations, food or beverages.

39 (d) Use of e-mail, internet activity or social media messages, only
40 if the individual's use is not paid for by the individual or any other
41 person and if the e-mails, social media messages or other internet
42 activities do not contain or include transmittal of a paid advertisement
43 or paid fund-raising solicitation.

1 2. The costs incurred for covering or carrying a news story,
2 commentary or editorial by a broadcasting station or cable television
3 operator, VIDEO SERVICE PROVIDER, an internet website, a newspaper or
4 another periodical publication, including an internet-based or electronic
5 publication, if the cost for the news story, commentary or editorial is
6 not paid for by and the medium is not owned or under the control of a
7 candidate or committee.

8 3. Any payment to defray the expense of an elected official meeting
9 with constituents or attending an informational tour, conference, seminar
10 or presentation, if the payor or the elected official does not attempt to
11 influence the result of an election and the payment is reported if
12 required pursuant to title 38, chapter 3.1 or title 41, chapter 7, article
13 8.1, or both.

14 4. The payment by a political party to support its nominee,
15 including:

16 (a) The printing or distribution of, or postage expenses for, voter
17 guides, sample ballots, pins, bumper stickers, handbills, brochures,
18 posters, yard signs and other similar materials distributed through the
19 party.

20 (b) Coordinated ~~political~~ party expenditures.

21 5. The payment by any person to defray a political party's
22 operating expenses or party-building activities, including:

23 (a) Party staff and personnel.

24 (b) Studies and reports.

25 (c) Voter registration, recruitment, polling and turnout efforts.

26 (d) Party conventions and party meetings.

27 (e) Construction, purchase or lease of party buildings or
28 facilities.

29 6. The value of any of the following to a committee:

30 (a) Interest earned on the committee's deposits or investments.

31 (b) Transfers between committees to reimburse expenses and
32 distribute monies raised through a joint fund-raising effort, if the
33 transfers comply with an agreement to reimburse and distribute monies that
34 was executed before the joint fund-raising effort occurred.

35 (c) Payment of a committee's legal or accounting expenses by any
36 person.

37 (d) An extension of credit for goods and services on a committee's
38 behalf by a creditor if the terms are substantially similar to extensions
39 of credit to nonpolitical debtors that are of similar risk and size of
40 obligation. The creditor must make a commercially reasonable attempt to
41 collect the debt, except that if an extension of credit remains
42 unsatisfied by the committee after six months the committee is deemed to
43 have received a contribution but the creditor is not deemed to have made a
44 contribution.

1 7. The value of nonpartisan communications that are intended to
2 encourage voter registration and turnout efforts.

3 8. Any payment to a filing officer for arguments in a publicity
4 pamphlet.

5 9. The payment by any sponsor or its affiliate for the costs of
6 establishing, administering and soliciting contributions from its
7 employees, members, executives, stockholders and retirees and their
8 families to the sponsor's separate segregated fund.

9 10. Any payment by any entity for the costs of communicating with
10 its employees, members, executives, stockholders and retirees and their
11 families about any subject, without regard to whether those communications
12 are made in coordination with any candidate or candidate's agent.

13 11. The value of allowing a candidate or a committee's
14 representative to appear at any private residence or at the facilities of
15 any entity to speak about the candidate's campaign or about a ballot
16 measure, if the venue is furnished by the venue's owner, is not paid for
17 by a third party and is not a sports stadium, coliseum, convention center,
18 hotel ballroom, concert hall or other similar arena that is generally open
19 to the public.

20 12. The costs of hosting a debate or candidates' forum, if at least
21 two opposing candidates, with respect to any given office sought, or
22 representatives of at least two opposing ballot measure campaigns, with
23 respect to any measure on the ballot, are invited with the same or similar
24 advance notice and method of invitation.

25 13. The preparation and distribution of voter guides, subject to
26 the following:

27 (a) A featured candidate or ballot measure shall not receive
28 greater prominence or substantially more space in the voter guide than any
29 other candidate or ballot measure.

30 (b) The voter guide shall not include any message that constitutes
31 express advocacy.

32 14. Monies that are loaned by a financial institution in the
33 ordinary course of business and not for the purpose of influencing the
34 results of an election, except that the loan is deemed a pro rata
35 contribution by any endorser or guarantor, other than the candidate's
36 spouse.

37 15. The costs of publishing a book or producing a documentary, if
38 the publication and production are for distribution to the general public
39 through traditional distribution mechanisms or a fee is obtained for the
40 purchase of the publication or viewing of the documentary.

41 C. This section does not imply that any transactions that are not
42 specifically listed in subsection B of this section are contributions
43 unless those transactions otherwise meet the definition of contribution as
44 defined in section 16-901.

1 Sec. 9. Section 16-921, Arizona Revised Statutes, is amended to
2 read:

3 16-921. Exemptions from definition of expenditure

4 A. A person may make any expenditure not otherwise prohibited by
5 law.

6 B. The following are not expenditures:

7 1. The value of an individual's volunteer services or expenses that
8 are provided without compensation or reimbursement, including the
9 individual's:

10 (a) Travel expenses.

11 (b) Use of real or personal property.

12 (c) Cost of invitations, food or beverages.

13 (d) Use of e-mail, internet activity or social media messages, only
14 if the individual's use is not paid for by the individual or any other
15 person and if the e-mails, social media messages or other internet
16 activities do not contain or include transmittal of a paid advertisement
17 or paid fund-raising solicitation.

18 2. The value of any news story, commentary or editorial by any
19 broadcasting station, cable television operator, VIDEO SERVICE PROVIDER,
20 programmer or producer, newspaper, magazine, website or other periodical
21 publication that is not owned or operated by a candidate, a candidate's
22 spouse or any committee.

23 3. The payment by any person to defray a political party's
24 operating expenses or party-building activities, including:

25 (a) Party staff and personnel.

26 (b) Studies and reports.

27 (c) Voter registration, recruitment, polling and turnout efforts.

28 (d) Party conventions and party meetings.

29 (e) Construction, purchase or lease of party buildings or
30 facilities.

31 4. The value of any of the following to a committee:

32 (a) Interest earned on the committee's deposits or investments.

33 (b) Transfers between committees to reimburse expenses and
34 distribute monies raised through a joint fund-raising effort, except that
35 contributions shall be allocated as described in the fund-raising
36 solicitation and expenses shall be allocated in the same proportion as
37 contributions.

38 (c) Payment of a committee's legal or accounting expenses.

39 (d) An extension of credit for goods and services on a committee's
40 behalf by a creditor if the terms are substantially similar to extensions
41 of credit to nonpolitical debtors that are of similar risk and size of
42 obligation. The creditor must make a commercially reasonable attempt to
43 collect the debt, except that if an extension of credit remains
44 unsatisfied by the committee after six months the committee is deemed to

1 have received a contribution but the creditor is not deemed to have made a
2 contribution.

3 5. The value of nonpartisan communications that are intended to
4 encourage voter registration and turnout efforts.

5 6. Any payment by a person that is not a committee to a filing
6 officer for arguments in a publicity pamphlet.

7 7. Any payment for legal or accounting services that are provided
8 to a committee.

9 8. The payment of costs of publishing a book or producing a
10 documentary, if the publication and production are for distribution to the
11 general public through traditional distribution mechanisms or a fee is
12 obtained for the purchase of the publication or viewing of the
13 documentary.

14 C. This section does not imply that any transactions that are not
15 specifically listed in subsection B of this section are expenditures
16 unless those transactions otherwise meet the definition of expenditure as
17 defined in section 16-901.

18 Sec. 10. Section 18-502, Arizona Revised Statutes, is amended to
19 read:

20 18-502. Prohibited activities; applicability

21 A. It is unlawful for any person who is not an owner or operator of
22 a computer to transmit computer software to a computer, with actual
23 knowledge or with conscious avoidance of actual knowledge, and to use the
24 software to do any of the following:

25 1. Modify, through intentionally deceptive means, settings that
26 control any of the following:

27 (a) The page that appears when an owner or operator of a computer
28 launches an internet browser or similar computer software used to access
29 and navigate the internet.

30 (b) The default provider or web proxy that an owner or operator of
31 a computer uses to access or search the internet.

32 (c) An owner's or operator's list of bookmarks used to access web
33 pages.

34 2. Collect, through intentionally deceptive means, personally
35 identifiable information:

36 (a) Through the use of a keystroke logging function that records
37 all keystrokes made by an authorized user who uses the computer and
38 transfers that information from the computer to another person.

39 (b) In a manner that correlates the information with data
40 respecting all or substantially all of the websites visited by an owner or
41 operator of the computer, other than websites operated by the person
42 collecting the information.

43 (c) With respect only to information described in section 18-501,
44 paragraph 9, by extracting such information from the hard drive of an
45 owner's or operator's computer.

1 3. Prevent, through intentionally deceptive means, an owner's or
2 operator's reasonable efforts to block the installation or execution of,
3 or to disable, computer software by causing software that an owner or
4 operator of the computer has properly removed or disabled automatically to
5 reinstall or reactivate on the computer.

6 4. Intentionally misrepresent that computer software will be
7 uninstalled or disabled by an owner's or operator's action.

8 5. Through intentionally deceptive means, remove, disable or render
9 inoperative security, antispyware or antivirus computer software installed
10 on the computer.

11 6. Take control of the computer by:

12 (a) Accessing or using the modem or internet service for the
13 computer for the purpose of causing damage to the computer or causing an
14 owner or operator to incur financial charges for a service that the owner
15 or operator of the computer has not authorized.

16 (b) Opening multiple, sequential, stand-alone advertisements in an
17 owner's or operator's internet browser without the authorization of the
18 owner or operator that a reasonable computer user cannot close without
19 turning off the computer or closing the internet browser.

20 7. Modify any of the following settings related to the computer's
21 access to, or use of, the internet:

22 (a) Settings that protect information about an owner or operator of
23 the computer for the purpose of stealing personally identifiable
24 information of the owner or operator.

25 (b) Security settings for the purpose of causing damage to a
26 computer.

27 8. Prevent an owner's or operator's reasonable efforts to block the
28 installation of, or to disable, computer software, by doing either of the
29 following:

30 (a) Presenting the owner or operator with an option to decline
31 installation of computer software with knowledge that, if the option is
32 selected, the installation nevertheless proceeds.

33 (b) Falsely representing that computer software has been disabled.

34 B. It is unlawful for any person who is not an owner or operator of
35 a computer to do either of the following with regard to the computer:

36 1. Induce an owner or operator to install a computer software
37 component on the computer by intentionally misrepresenting the extent to
38 which installing the software is necessary for security or privacy reasons
39 or in order to open, view or play a particular type of content.

40 2. Deceptively cause the execution on the computer of a computer
41 software component with the intent of causing an owner or operator to use
42 the component in a manner that violates any other provision of this
43 section.

44 C. This section does not apply to any monitoring of, or interaction
45 with, a subscriber's internet or other network connection or service, or a

1 computer, by a telecommunications carrier, cable operator, VIDEO SERVICE
2 PROVIDER, computer hardware or software provider or provider of
3 information service or interactive computer service for network or
4 computer security purposes, diagnostics, technical support, maintenance,
5 repair, authorized updates of software or system firmware, authorized
6 remote system management or detection or prevention of the unauthorized
7 use of or fraudulent or other illegal activities in connection with a
8 network, service or computer software, including scanning for and removing
9 software prescribed under this article.

10 Sec. 11. Section 26-320, Arizona Revised Statutes, is amended to
11 read:

12 26-320. First informer broadcasters; training and
13 certification; access; definitions

14 A. The division may coordinate with a broadcasting association in
15 this state or a cable television telecommunication association in this
16 state, or both, to develop comprehensive, coordinated plans for preparing
17 for and responding appropriately to an emergency or disaster.

18 B. The division may designate and authorize a statewide
19 organization that represents broadcasters, cable television communications
20 or any other provider that uses emerging technologies or a federally
21 licensed radio or television station to establish and conduct a program
22 approved by the division to train and certify broadcast engineers and
23 technical personnel that are critical to station operations as first
24 informer broadcasters. Training and certification pursuant to this
25 subsection shall:

26 1. Be consistent with federal law and guidelines.

27 2. Include education in restoring, repairing and resupplying any
28 facilities or equipment of a broadcaster in an area affected by an
29 emergency or disaster.

30 3. Include education concerning the personal safety of a first
31 informer broadcaster in an area affected by an emergency or disaster.

32 C. To the extent practicable and consistent with not endangering
33 public safety or inhibiting recovery efforts, state and local government
34 agencies shall allow a first informer broadcaster to access an area
35 affected by an emergency or disaster to restore, repair or resupply any
36 facility or equipment critical to the ability of a broadcaster to acquire,
37 produce and transmit essential emergency or disaster related public
38 information programming, including repairing and maintaining transmitters
39 and generators and transporting fuel for generators.

40 D. For the purposes of this section:

41 1. "Broadcaster" means a radio broadcasting station, cable
42 TELEVISION operator, VIDEO SERVICE PROVIDER or television broadcasting
43 station primarily engaged in, and deriving income from, the business of
44 facilitating speech via over-the-air communications, both as to pure
45 speech and commercial speech.

1 2. "First informer broadcaster" means a person who is trained and
2 certified as a first informer broadcaster pursuant to this section.

3 Sec. 12. Section 40-283, Arizona Revised Statutes, is amended to
4 read:

5 40-283. Transmission lines; use of public streets for utility
6 right-of-way; notice; election

7 A. Any person engaged in transportation or transmission business
8 within the state may construct and operate lines connecting any points
9 within the state and connect at the state boundary with like lines, except
10 that within the confines of municipal corporations the use and occupancy
11 of streets shall be under rights acquired by franchises according to law
12 or licenses pursuant to title 9, chapter 5, articles 1.1 and 4, and
13 subject to control and regulation by the municipal authorities. The use
14 of highways, except state highways, by public utilities not within any
15 incorporated city or town shall be regulated by the board of supervisors
16 of the county by license or franchise.

17 B. A board of supervisors in granting a license or franchise, or at
18 any time after it is granted, may impose restrictions and limitations upon
19 the use of the public roads as it deems best for the public safety or
20 welfare.

21 C. Every franchise granted under this article shall include
22 provisions requiring the grantee to bear all expenses, including damage
23 and compensation for any alteration of the direction, surface, grade or
24 alignment of a county road, made for the purpose of such franchise. If
25 the surface of a county highway is used by any grantee for trackage, the
26 franchise shall include reasonable regulations for maintenance by the
27 grantee of that portion of the highway so used.

28 D. A board of supervisors may authorize public service
29 corporations, telecommunications corporations, ~~or cable television systems~~
30 ~~OPERATORS OR VIDEO SERVICE PROVIDERS~~ to construct a line, plant, service
31 or system within the right-of-way of any road, highway or easement that is
32 designated for access or public use by plat or survey of record of a
33 subdivision, or of unsubdivided land as defined in section 32-2101,
34 provided that any such authorization or construction pursuant to such
35 authorization does not impose on the county the duty of maintaining the
36 road or highway unless the county accepts the road or highway into the
37 county maintenance system by appropriate resolution. ~~Nothing contained in~~
38 This subsection ~~shall be construed to~~ DOES NOT grant county boards of
39 supervisors additional authority to require public service corporations,
40 telecommunications corporations, ~~or cable television systems~~ ~~OPERATORS OR~~
41 ~~VIDEO SERVICE PROVIDERS~~ to obtain licenses or franchises.

42 E. A board of supervisors, before granting any of the privileges
43 authorized under this section, shall give public notice of its intention
44 to ~~make such~~ grant SUCH PRIVILEGES by publishing notice in a newspaper of
45 general circulation, published within the county, at least once a week for

1 three weeks ~~prior to~~ BEFORE the day set for consideration of such action.
2 If, on or before such date, more than fifty ~~per cent~~ PERCENT of the
3 qualified electors of the county petition the board of supervisors to deny
4 ~~such~~ THE privilege, it shall do so, and any privilege granted against ~~such~~
5 THE petition ~~shall be~~ IS void.

6 Sec. 13. Section 40-341, Arizona Revised Statutes, is amended to
7 read:

8 40-341. Definitions

9 In this article, unless the context otherwise requires:

10 1. "Clerk" means the clerk of the board of supervisors or any
11 person or officer who acts as clerk of the board of supervisors.

12 2. "Convert" or "conversion" means the removal of existing overhead
13 electric or communication facilities and the replacement thereof with
14 underground electric or communication facilities constructed at the same
15 or different locations.

16 3. "Electric or communication facilities" means any works or
17 improvements used or useful in providing electric, communication or cable
18 television service OR VIDEO SERVICE, including ~~but not limited to~~ poles,
19 supports, tunnels, manholes, vaults, conduits, pipes, wires, conductors,
20 guys, stubs, platforms, crossarms, braces, transformers, insulators,
21 cutouts, switches, capacitors, meters, communication circuits, appliances,
22 attachments and appurtenances. ~~"Electric facilities" shall~~ DOES not
23 include any facilities used or intended to be used for the transmission of
24 electric energy at nominal voltages in excess of twenty-five thousand
25 volts or having a circuit capacity in excess of twelve thousand
26 kva. ~~"Communication facilities" shall~~ DOES not include facilities used
27 or intended to be used for the transmission of intelligence by microwave
28 or radio, apparatus cabinets or outdoor public telephones.

29 4. "Local government" means the city or town council if all or any
30 part of the underground conversion service area is located within the
31 limits of an incorporated city or town or the county board of supervisors
32 if the underground conversion service area is located in an unincorporated
33 area.

34 5. "Lot" includes any portion, piece, parcel or subdivision of
35 land, but not property owned or controlled by any person as a right of
36 way.

37 6. "Owner" means the person in whom legal title appears by recorded
38 deed, or the person in possession under claim of title, or the person
39 exercising acts of ownership for ~~himself~~ THE PERSON or as the personal
40 representative of the owner, including the boards of trustees of school
41 districts and the boards of education of high school districts owning
42 property within the underground conversion service area.

43 7. "Overhead electric or communication facilities" means electric
44 or communication facilities located above the surface of the ground,
45 except as provided for in paragraphs 3 and 12 of this section.

1 8. "Public agency" means any irrigation, power, electrical or
2 agricultural improvement district now or hereafter organized that provides
3 electric or communication service to the public by means of electric or
4 communication facilities.

5 9. "Public place" includes streets, alleys, roadways, sidewalks,
6 rights of way, easements and similar properties as to which a city, town,
7 county, the state, the public service corporation or the public agency may
8 have a right.

9 10. "Public service corporation" means any person or corporation
10 that provides electric or communication service to the public by means of
11 electric or communication facilities.

12 11. "Real property" means the real estate owned in fee, but not
13 inclusive of buildings or structures located thereon, or any property
14 owned or controlled as a railroad or street ~~right of way~~ RIGHT-OF-WAY.

15 12. "Underground conversion service area" means an area in which
16 existing electric and communication facilities are to be placed
17 underground, exclusive of any lines or facilities used or intended to be
18 used for the transmission of electric energy at nominal voltages in excess
19 of twenty-five thousand volts or having a circuit capacity in excess of
20 twelve thousand kva and facilities used or intended to be used for the
21 transmission of intelligence by microwave or radio and facilities such as
22 transformers, pull boxes, service terminals, pedestal terminals, splice
23 closures, apparatus cabinets and similar facilities ~~which~~ THAT normally
24 are above the surface in areas where service lines are underground in
25 accordance with standard underground practices, and on-the-ground
26 facilities attached to overhead facilities ~~which~~ THAT are used to connect
27 an underground system to overhead facilities.

28 13. "Underground conversion cost" means the costs to be paid by
29 each owner to each public service corporation or public agency by the
30 property owners within an underground conversion service area, as provided
31 in this article.

32 Sec. 14. Section 40-354, Arizona Revised Statutes, is amended to
33 read:

34 40-354. No extension of corporation commission jurisdiction
35 to public agencies, video service networks or cable
36 television systems

37 Nothing contained in this article ~~shall vest~~ VESTS any jurisdiction
38 over public agencies, VIDEO SERVICE NETWORKS or cable television systems
39 in the Arizona corporation commission.

40 Sec. 15. Section 40-360.24, Arizona Revised Statutes, is amended to
41 read:

42 40-360.24. Notice of damage to underground facility

43 A. In the event of any damage that results in a release from any
44 underground facility that transports natural gas, liquefied petroleum gas,
45 liquefied natural gas, petroleum products or any other hazardous gases or

1 liquids in connection with any excavation, the person responsible for the
2 excavation operations shall immediately notify the underground facilities
3 operator and 911 or the local emergency response agency.

4 B. In the event of any damage to or dislocation of any underground
5 facility or detectible underground location device in connection with any
6 excavation the person responsible for the excavation operations shall
7 immediately notify the underground facilities operator and shall not
8 attempt any repair to the damaged facility or device except the temporary
9 emergency repairs allowed by this section.

10 C. Temporary emergency repairs shall not be made by an excavator to
11 a public utility's or municipal corporation's natural gas, electric,
12 propane, hazardous liquid, communication, cable television **SYSTEM OR VIDEO**
13 **SERVICE NETWORK**, sewer system, wastewater or water facilities without the
14 consent of the underground facilities operator.

15 D. The excavation shall be left open until the arrival of
16 representatives of the underground facilities operator. ~~Upon~~ **ON** receipt
17 of notice, the underground facilities operator shall dispatch its
18 representatives promptly, but in no event later than two working days, to
19 examine the underground facility and, if necessary, effect repairs.
20 Unless it would interfere with compliance with commission rules or
21 requirements regarding maintenance or restoration of service and repair of
22 facilities, the underground facilities operator shall immediately respond
23 to a notification for emergencies involving injury or damage.

24 Sec. 16. Section 40-360.41, Arizona Revised Statutes, is amended to
25 read:

26 **40-360.41. Definitions**

27 In this article, unless the context otherwise requires:

28 1. "Authorized person" means:

29 (a) An employee of a public utility ~~which~~ **THAT** produces, transmits
30 or delivers electricity.

31 (b) An employee of a public utility ~~which~~ **THAT** provides and whose
32 work relates to communication services or state, county or municipal
33 agencies ~~which~~ **THAT** have authorized circuit construction on or near the
34 poles or structures of a public utility.

35 (c) An employee of an industrial plant whose work relates to the
36 electrical system of the industrial plant.

37 (d) An employee of a cable television **OPERATOR, VIDEO SERVICE**
38 **PROVIDER** or communication services company or an employee of a contractor
39 of a cable television **OPERATOR, VIDEO SERVICE PROVIDER** or communication
40 services company if specifically authorized by the owner of the poles to
41 make **ATTACHMENTS FOR** cable television or communication services
42 ~~attachments~~ **OR VIDEO SERVICES**.

43 (e) An employee or agent of state, county or municipal agencies
44 ~~which~~ **THAT** have or whose work relates to overhead electrical lines or
45 circuit construction or conductors on poles or structures of any type.

1 2. "High voltage" means voltage in excess of six hundred volts
2 measured between conductors or between a conductor and the ground.

3 3. "Overhead line" means all bare or insulated electrical
4 conductors installed aboveground.

5 4. "Person" or "business entity" means those parties ~~who~~ THAT
6 contract to perform any function or activity ~~upon~~ ON any land, building,
7 highway or other premises.

8 5. "Public utility" includes public service corporations,
9 municipally owned systems and districts subject to article XIII, section
10 7, Constitution of Arizona.

11 Sec. 17. Section 40-491, Arizona Revised Statutes, is amended to
12 read:

13 40-491. Definitions

14 In this article, unless the context otherwise requires:

15 1. "Customer" means the person in whose name a utility service is
16 provided.

17 2. "Person" means an individual, partnership, firm, association or
18 corporation.

19 3. "Reconnection" means the restoration of utility service to a
20 customer or other person after service has been legally disconnected by
21 the utility.

22 4. "Tamper" or "tampering" means any of the following if committed
23 against property that is owned or operated by the utility for transmission
24 or distribution:

25 (a) Rearranging, damaging, altering, interfering with or otherwise
26 preventing the performance of a normal or customary function of utility
27 property.

28 (b) Connecting any wire, conduit or device to any utility property.

29 (c) Defacing, puncturing, removing, reversing or altering any
30 utility property.

31 (d) Preventing any meter from properly measuring or registering.

32 (e) Knowingly taking, receiving, using or converting to personal
33 use or the use of another any utility service that has not been measured
34 or authorized.

35 (f) Diverting or changing the intended course or path of the
36 utility service without the authorization or consent of the utility.

37 (g) Causing, procuring, permitting, aiding or abetting any person
38 to do any of the acts listed in this paragraph.

39 5. "Utility" means any public service corporation, licensed cable
40 television system OR VIDEO SERVICE NETWORK, telephone line or telegraph
41 line corporation or person engaged in the generation, transmission or
42 delivery of electricity, gas, telephone, cable television, telegraph or
43 water service, including this state or any political subdivision or agency
44 of this state.

1 6. "Utility service" means the provision of services or commodities
2 by the utility for compensation.

3 Sec. 18. Section 41-1954, Arizona Revised Statutes, is amended to
4 read:

5 41-1954. Powers and duties

6 A. In addition to the powers and duties of the agencies listed in
7 section 41-1953, subsection E, the department shall:

8 1. Administer the following services:

9 (a) Employment services, including manpower programs and work
10 training, field operations, technical services, unemployment compensation,
11 community work and training and other related functions in furtherance of
12 programs under the social security act, as amended, the Wagner-Peyser act,
13 as amended, the federal unemployment tax act, as amended, 33 United States
14 Code, the family support act of 1988 (P.L. 100-485) and other related
15 federal acts and titles.

16 (b) Individual and family services, which shall include a section
17 on aging, services to children, youth and adults and other related
18 functions in furtherance of social service programs under the social
19 security act, as amended, title IV, except parts B and E, grants to states
20 for aid and services to needy families with children and for ~~child-welfare~~
21 ~~CHILD WELFARE~~ services, title XX, grants to states for services, the older
22 Americans act, as amended, the family support act of 1988 (P.L. 100-485)
23 and other related federal acts and titles.

24 (c) Income maintenance services, including categorical assistance
25 programs, special services unit, child support collection services,
26 establishment of paternity services, maintenance and operation of a state
27 case registry of child support orders, a state directory of new hires, a
28 support payment clearinghouse and other related functions in furtherance
29 of programs under the social security act, title IV, grants to states for
30 aid and services to needy families with children and for ~~child-welfare~~
31 ~~CHILD WELFARE~~ services, title XX, grants to states for services, as
32 amended, and other related federal acts and titles.

33 (d) Rehabilitation services, including vocational rehabilitation
34 services and sections for the blind and visually impaired, communication
35 disorders, correctional rehabilitation and other related functions in
36 furtherance of programs under the vocational rehabilitation act, as
37 amended, the Randolph-Sheppard act, as amended, and other related federal
38 acts and titles.

39 (e) Administrative services, including the coordination of program
40 evaluation and research, interagency program coordination and in-service
41 training, planning, grants, development and management, information,
42 legislative liaison, budget, licensing and other related functions.

43 (f) Manpower planning, including a state manpower planning council
44 for the purposes of the federal-state-local cooperative manpower planning
45 system and other related functions in furtherance of programs under the

1 comprehensive employment and training act of 1973, as amended, and other
2 related federal acts and titles.

3 (g) Economic opportunity services, including the furtherance of
4 programs prescribed under the economic opportunity act of 1967, as
5 amended, and other related federal acts and titles.

6 (h) Intellectual disability and other developmental disability
7 programs, with emphasis on referral and purchase of services. The program
8 shall include educational, rehabilitation, treatment and training services
9 and other related functions in furtherance of programs under the
10 developmental disabilities services and facilities construction
11 act, ~~Public Law (P.L. 91-517),~~ and other related federal acts and titles.

12 (i) Nonmedical home and community based services and functions,
13 including ~~department designated~~ DEPARTMENT-DESIGNATED case management,
14 housekeeping services, chore services, home health aid, personal care,
15 visiting nurse services, adult day care or adult day health, respite
16 sitter care, attendant care, home delivered meals and other related
17 services and functions.

18 2. Provide a coordinated system of initial intake, screening,
19 evaluation and referral of persons served by the department.

20 3. Adopt rules it deems necessary or desirable to further the
21 objectives and programs of the department.

22 4. Formulate policies, plans and programs to effectuate the
23 missions and purposes of the department.

24 5. Employ and determine the conditions of employment and prescribe
25 the duties and powers of administrative, professional, technical,
26 secretarial, clerical and other persons subject to chapter 4, article 4
27 and, as applicable, article 5 of this title as may be necessary in the
28 performance of its duties, contract for the services of outside advisors,
29 consultants and aides as may be reasonably necessary and reimburse
30 department volunteers, designated by the director, for expenses in
31 transporting clients of the department on official business.

32 6. Make contracts and incur obligations within the general scope of
33 its activities and operations subject to the availability of funds.

34 7. Contract with or assist other departments, agencies and
35 institutions of the state, local and federal governments in the
36 furtherance of its purposes, objectives and programs.

37 8. Be designated as the single state agency for the purposes of
38 administering and in furtherance of each federally supported state plan.

39 9. Accept and disburse grants, matching funds and direct payments
40 from public or private agencies for the conduct of programs that are
41 consistent with the overall purposes and objectives of the department.

42 10. Provide information and advice on request by local, state and
43 federal agencies and by private citizens, business enterprises and
44 community organizations on matters within the scope of its duties subject
45 to the departmental rules on the confidentiality of information.

1 11. Establish and maintain separate financial accounts as required
2 by federal law or regulations.

3 12. Advise and make recommendations to the governor and the
4 legislature on all matters concerning its objectives.

5 13. Have an official seal that ~~shall be~~ IS judicially noticed.

6 14. Annually estimate the current year's population of each county,
7 city and town in this state, using the periodic census conducted by the
8 United States department of commerce, or its successor agency, as the
9 basis for such estimates and deliver such estimates to the economic
10 estimates commission before December 15.

11 15. Estimate the population of any newly annexed areas of a
12 political subdivision as of July 1 of the fiscal year in which the
13 annexation occurs and deliver such estimates as promptly as is feasible
14 after the annexation occurs to the economic estimates commission.

15 16. Establish and maintain a statewide program of services for
16 persons who are both hearing impaired and visually impaired and coordinate
17 appropriate services with other agencies and organizations to avoid
18 duplication of these services and to increase efficiency. The department
19 of economic security shall enter into agreements for the utilization of
20 the personnel and facilities of the department of economic security, the
21 department of health services and other appropriate agencies and
22 organizations in providing these services.

23 17. Establish and charge fees for deposit in the department of
24 economic security prelayoff assistance services fund to employers who
25 voluntarily participate in the services of the department that provide job
26 service and retraining for persons who have been or are about to be laid
27 off from employment. The department shall charge only those fees
28 necessary to cover the costs of administering the job service and
29 retraining services.

30 18. Establish a focal point for addressing the issue of hunger in
31 ~~Arizona~~ THIS STATE and provide coordination and assistance to public and
32 private nonprofit organizations that aid hungry persons and families
33 throughout this state. Specifically such activities shall include:

34 (a) Collecting and disseminating information regarding the location
35 and availability of surplus food for distribution to needy persons, the
36 availability of surplus food for donation to charity food bank
37 organizations, and the needs of charity food bank organizations for
38 surplus food.

39 (b) Coordinating the activities of federal, state, local and
40 private nonprofit organizations that provide food assistance to the
41 hungry.

42 (c) Accepting and disbursing federal monies, and any state monies
43 appropriated by the legislature, to private nonprofit organizations in
44 support of the collection, receipt, handling, storage and distribution of
45 donated or surplus food items.

1 (d) Providing technical assistance to private nonprofit
2 organizations that provide or intend to provide services to the hungry.

3 (e) Developing a state plan on hunger that, at a minimum,
4 identifies the magnitude of the hunger problem in this state, the
5 characteristics of the population in need, the availability and location
6 of charity food banks and the potential sources of surplus food, assesses
7 the effectiveness of the donated food collection and distribution network
8 and other efforts to alleviate the hunger problem, and recommends goals
9 and strategies to improve the status of the hungry. The state plan on
10 hunger shall be incorporated into the department's state comprehensive
11 plan prepared pursuant to section 41-1956.

12 (f) Establishing a special purpose advisory council on hunger
13 pursuant to section 41-1981.

14 19. Establish an office to address the issue of homelessness and to
15 provide coordination and assistance to public and private nonprofit
16 organizations that prevent homelessness or aid homeless individuals and
17 families throughout this state. These activities shall include:

18 (a) Promoting and participating in planning for the prevention of
19 homelessness and the development of services to homeless persons.

20 (b) Identifying and developing strategies for resolving barriers in
21 state agency service delivery systems that inhibit the provision and
22 coordination of appropriate services to homeless persons and persons in
23 danger of being homeless.

24 (c) Assisting in the coordination of the activities of federal,
25 state and local governments and the private sector that prevent
26 homelessness or provide assistance to homeless people.

27 (d) Assisting in obtaining and increasing funding from all
28 appropriate sources to prevent homelessness or assist in alleviating
29 homelessness.

30 (e) Serving as a clearinghouse on information regarding funding and
31 services available to assist homeless persons and persons in danger of
32 being homeless.

33 (f) Developing an annual state comprehensive homeless assistance
34 plan to prevent and alleviate homelessness.

35 (g) Submitting an annual report to the governor, the president of
36 the senate and the speaker of the house of representatives on the status
37 of homelessness and efforts to prevent and alleviate homelessness. **THE**
38 **DEPARTMENT SHALL PROVIDE A COPY OF THIS REPORT TO THE SECRETARY OF STATE.**

39 20. Cooperate with the Arizona-Mexico commission in the governor's
40 office and with researchers at universities in this state to collect data
41 and conduct projects in the United States and Mexico on issues that are
42 within the scope of the department's duties and that relate to quality of
43 life, trade and economic development in this state in a manner that will
44 help the Arizona-Mexico commission to assess and enhance the economic
45 competitiveness of this state and of the Arizona-Mexico region.

1 21. Exchange information, including case specific information, and
2 cooperate with the department of child safety for the administration of
3 the department of child safety's programs.

4 B. If the department of economic security has responsibility for
5 the care, custody or control of a child or is paying the cost of care for
6 a child, it may serve as representative payee to receive and administer
7 social security and United States department of veterans affairs benefits
8 and other benefits payable to such child. Notwithstanding any law to the
9 contrary, the department of economic security:

10 1. Shall deposit, pursuant to sections 35-146 and 35-147, such
11 monies as it receives to be retained separate and apart from the state
12 general fund on the books of the department of administration.

13 2. May use such monies to defray the cost of care and services
14 expended by the department of economic security for the benefit, welfare
15 and best interests of the child and invest any of the monies that the
16 director determines are not necessary for immediate use.

17 3. Shall maintain separate records to account for the receipt,
18 investment and disposition of funds received for each child.

19 4. On termination of the department of economic security's
20 responsibility for the child, shall release any funds remaining to the
21 child's credit in accordance with the requirements of the funding source
22 or in the absence of such requirements shall release the remaining funds
23 to:

24 (a) The child, if the child is at least eighteen years of age or is
25 emancipated.

26 (b) The person responsible for the child if the child is a minor
27 and not emancipated.

28 C. Subsection B of this section does not pertain to benefits
29 payable to or for the benefit of a child receiving services under title
30 36.

31 D. Volunteers reimbursed for expenses pursuant to subsection A,
32 paragraph 5 of this section are not eligible for workers' compensation
33 under title 23, chapter 6.

34 E. In implementing the temporary assistance for needy families
35 program pursuant to Public Law 104-193, the department shall provide for
36 cash assistance to ~~two-parent~~ TWO-PARENT families if both parents are able
37 to work only on documented participation by both parents in work
38 activities described in title 46, chapter 2, article 5, except that
39 payments may be made to families who do not meet the participation
40 requirements if:

41 1. It is determined on an individual case basis that they have
42 emergency needs.

43 2. The family is determined to be eligible for diversion from
44 long-term cash assistance pursuant to title 46, chapter 2, article 5.

1 F. The department shall provide for cash assistance under temporary
2 assistance for needy families pursuant to Public Law 104-193 to ~~two-parent~~
3 ~~TWO-PARENT~~ families for no longer than six months if both parents are able
4 to work, except that additional assistance may be provided on an
5 individual case basis to families with extraordinary circumstances. The
6 department shall establish by rule the criteria to be used to determine
7 eligibility for additional cash assistance.

8 G. The department shall adopt the following discount medical
9 payment system for persons who the department determines are eligible and
10 who are receiving rehabilitation services pursuant to subsection A,
11 paragraph 1, subdivision ~~(c)~~ (d) of this section:

12 1. For inpatient hospital admissions and outpatient hospital
13 services the department shall reimburse a hospital according to the rates
14 established by the Arizona health care cost containment system
15 administration pursuant to section 36-2903.01, subsection G.

16 2. The department's liability for a hospital claim under this
17 subsection is subject to availability of funds.

18 3. A hospital bill is considered received for purposes of
19 paragraph 5 of this subsection on initial receipt of the legible,
20 error-free claim form by the department if the claim includes the
21 following error-free documentation in legible form:

- 22 (a) An admission face sheet.
- 23 (b) An itemized statement.
- 24 (c) An admission history and physical.
- 25 (d) A discharge summary or an interim summary if the claim is
26 split.
- 27 (e) An emergency record, if admission was through the emergency
28 room.
- 29 (f) Operative reports, if applicable.
- 30 (g) A labor and delivery room report, if applicable.

31 4. The department shall require that the hospital pursue other
32 third-party payors before submitting a claim to the department. Payment
33 received by a hospital from the department pursuant to this subsection is
34 considered payment by the department of the department's liability for the
35 hospital bill. A hospital may collect any unpaid portion of its bill from
36 other ~~third-party~~ ~~THIRD-PARTY~~ payors or in situations covered by title 33,
37 chapter 7, article 3.

38 5. For inpatient hospital admissions and outpatient hospital
39 services rendered on and after October 1, 1997, if the department receives
40 the claim directly from the hospital, the department shall pay a
41 hospital's rate established according to this section subject to the
42 following:

- 43 (a) If the hospital's bill is paid within thirty days of the date
44 the bill was received, the department shall pay ninety-nine ~~per cent~~
45 ~~PERCENT~~ of the rate.

1 (b) If the hospital's bill is paid after thirty days but within
2 sixty days of the date the bill was received, the department shall pay one
3 hundred ~~per cent~~ PERCENT of the rate.

4 (c) If the hospital's bill is paid any time after sixty days of the
5 date the bill was received, the department shall pay one hundred ~~per cent~~
6 PERCENT of the rate plus a fee of one ~~per cent~~ PERCENT per month for each
7 month or portion of a month following the sixtieth day of receipt of the
8 bill until the date of payment.

9 6. For medical services other than those for which a rate has been
10 established pursuant to section 36-2903.01, subsection G, the department
11 shall pay according to the Arizona health care cost containment system
12 capped fee-for-service schedule adopted pursuant to section 36-2904,
13 subsection K or any other established fee schedule the department
14 determines reasonable.

15 H. The department shall not pay claims for services pursuant to
16 this section that are submitted more than nine months after the date of
17 service for which the payment is claimed.

18 I. To assist in the location of persons or assets for the purpose
19 of establishing paternity, establishing, modifying or enforcing child
20 support obligations and other related functions, the department has
21 access, including automated access if the records are maintained in an
22 automated database, to records of state and local government agencies,
23 including:

24 1. Vital statistics, including records of marriage, birth and
25 divorce.

26 2. State and local tax and revenue records, including information
27 on residence address, employer, income and assets.

28 3. Records concerning real and titled personal property.

29 4. Records of occupational and professional licenses.

30 5. Records concerning the ownership and control of corporations,
31 partnerships and other business entities.

32 6. Employment security records.

33 7. Records of agencies administering public assistance programs.

34 8. Records of the motor vehicle division of the department of
35 transportation.

36 9. Records of the state department of corrections.

37 10. Any system used by a state agency to locate a person for motor
38 vehicle or law enforcement purposes, including access to information
39 contained in the Arizona criminal justice information system.

40 J. Notwithstanding subsection I of this section, the department or
41 its agents shall not seek or obtain information on the assets of an
42 individual unless paternity is presumed pursuant to section 25-814 or
43 established.

1 K. Access to records of the department of revenue pursuant to
2 subsection I of this section shall be provided in accordance with section
3 42-2003.

4 L. The department also has access to certain records held by
5 private entities with respect to child support obligors or obligees, or
6 individuals against whom such an obligation is sought. The information
7 shall be obtained as follows:

8 1. In response to a child support subpoena issued by the department
9 pursuant to section 25-520, the names and addresses of these persons and
10 the names and addresses of the employers of these persons, as appearing in
11 customer records of public utilities, ~~and cable television companies~~
12 ~~OPERATORS AND VIDEO SERVICE PROVIDERS.~~

13 2. Information on these persons held by financial institutions.

14 M. Pursuant to department rules, the department may compromise or
15 settle any support debt owed to the department if the director or an
16 authorized agent determines that it is in the best interest of ~~the~~ THIS
17 state and after considering each of the following factors:

18 1. The obligor's financial resources.

19 2. The cost of further enforcement action.

20 3. The likelihood of recovering the full amount of the debt.

21 N. Notwithstanding any law to the contrary, a state or local
22 governmental agency or private entity is not subject to civil liability
23 for the disclosure of information made in good faith to the department
24 pursuant to this section.

25 Sec. 19. Section 42-5063, Arizona Revised Statutes, is amended to
26 read:

27 42-5063. Utilities classification; definitions

28 A. The utilities classification is comprised of the business of:

29 1. Producing and furnishing or furnishing to consumers natural or
30 artificial gas and water.

31 2. Providing to retail electric customers ancillary services,
32 electric distribution services, electric generation services, electric
33 transmission services and other services related to providing electricity.

34 B. The utilities classification does not include:

35 1. Sales of ancillary services, electric distribution services,
36 electric generation services, electric transmission services and other
37 services related to providing electricity, gas or water to a person who
38 resells the services.

39 2. Sales of natural gas or liquefied petroleum gas used to propel a
40 motor vehicle.

41 3. Sales of alternative fuel, as defined in section 1-215, to a
42 used oil fuel burner who has received a permit to burn used oil or used
43 oil fuel under section 49-426 or 49-480.

44 4. Sales of ancillary services, electric distribution services,
45 electric generation services, electric transmission services and other

1 services that are related to providing electricity to a retail electric
2 customer who is located outside this state for use outside this state if
3 the electricity is delivered to a point of sale outside this state.

4 5. Sales or other transfers of renewable energy credits or any
5 other unit created to track energy derived from renewable energy
6 resources. For the purposes of this paragraph, "renewable energy credit"
7 means a unit created administratively by the corporation commission or
8 governing body of a public power utility to track kilowatt hours of
9 electricity derived from a renewable energy resource or the kilowatt hour
10 equivalent of conventional energy resources displaced by distributed
11 renewable energy resources.

12 6. The leasing or renting of space to make attachments to utility
13 poles as follows:

14 (a) By a person that is engaged in business under this section.

15 (b) To a person that is engaged in business under this section or
16 section 42-5064 or that is a cable operator.

17 C. The tax base for the utilities classification is the gross
18 proceeds of sales or gross income derived from the business, but the
19 following shall be deducted from the tax base:

20 1. Revenues received by a municipally owned utility in the form of
21 fees charged to persons constructing residential, commercial or industrial
22 developments or connecting residential, commercial or industrial
23 developments to a municipal utility system or systems if the fees are
24 segregated and used only for capital expansion, system enlargement or debt
25 service of the utility system or systems.

26 2. Revenues received by any person or persons owning a utility
27 system in the form of reimbursement or contribution compensation for
28 property and equipment installed to provide utility access to, on or
29 across the land of an actual utility consumer if the property and
30 equipment become the property of the utility. This deduction shall not
31 exceed the value of such property and equipment.

32 3. Gross proceeds of sales or gross income derived from sales to:

33 (a) Qualifying hospitals as defined in section 42-5001.

34 (b) A qualifying health care organization as defined in section
35 42-5001 if the tangible personal property is used by the organization
36 solely to provide health and medical related educational and charitable
37 services.

38 4. The portion of gross proceeds of sales or gross income that is
39 derived from sales to a qualified environmental technology manufacturer,
40 producer or processor as defined in section 41-1514.02 of a utility
41 product and that is used directly in environmental technology
42 manufacturing, producing or processing. This paragraph shall apply for
43 twenty full consecutive calendar or fiscal years from the date the first
44 paper manufacturing machine is placed in service. In the case of a
45 qualified environmental technology manufacturer, producer or processor who

1 does not manufacture paper, the time period shall begin with the date the
2 first manufacturing, processing or production equipment is placed in
3 service.

4 5. The portion of gross proceeds of sales or gross income
5 attributable to transfers of electricity by any retail electric customer
6 owning a solar photovoltaic energy generating system to an electric
7 distribution system, if the electricity transferred is generated by the
8 customer's system.

9 6. Gross proceeds of sales or gross income derived from sales of
10 electricity, natural gas or liquefied petroleum gas to a qualified
11 manufacturing or smelting business. A utility that claims this deduction
12 shall report each month, on a form prescribed by the department, the name
13 and address of each qualified manufacturing or smelting business for which
14 this deduction is taken. This paragraph applies to gas transportation
15 services. For the purposes of this paragraph:

16 (a) "Gas transportation services" means the services of
17 transporting natural gas to a natural gas customer or to a natural gas
18 distribution facility if the natural gas was purchased from a supplier
19 other than the utility.

20 (b) "Manufacturing" means the performance as a business of an
21 integrated series of operations that places tangible personal property in
22 a form, composition or character different from that in which it was
23 acquired and transforms it into a different product with a distinctive
24 name, character or use. Manufacturing does not include job printing,
25 publishing, packaging, mining, generating electricity or operating a
26 restaurant.

27 (c) "Qualified manufacturing or smelting business" means one of the
28 following:

29 (i) A business that manufactures or smelts tangible products in
30 this state, of which at least fifty-one percent of the manufactured or
31 smelted products will be exported out of state for incorporation into
32 another product or sold out of state for a final sale.

33 (ii) A business that derives at least fifty-one percent of its
34 gross income from the sale of manufactured or smelted products
35 manufactured or smelted by the business.

36 (iii) A business that uses at least fifty-one percent of its square
37 footage in this state for manufacturing or smelting and business
38 activities directly related to manufacturing or smelting.

39 (iv) A business that employs at least fifty-one percent of its
40 workforce in this state in manufacturing or smelting and business
41 activities directly related to manufacturing or smelting.

42 (v) A business that uses at least fifty-one percent of the value of
43 its capitalized assets in this state, as reflected on the business's books
44 and records, for manufacturing or smelting and business activities
45 directly related to manufacturing or smelting.

1 (d) "Smelting" means to melt or fuse a metalliferous mineral, often
2 with an accompanying chemical change, usually to separate the metal.

3 7. Gross proceeds of sales or gross income derived from sales of
4 electricity or natural gas to a business that operates an international
5 operations center in this state and that is certified by the Arizona
6 commerce authority pursuant to section 41-1520.

7 D. For the purposes of this section:

8 1. "Ancillary services" means those services so designated in
9 federal energy regulatory commission order 888 adopted in 1996 that
10 include the services necessary to support the transmission of electricity
11 from resources to loads while maintaining reliable operation of the
12 transmission system according to good utility practice.

13 2. "Cable operator" has the same meaning prescribed in section
14 9-505 AND INCLUDES A VIDEO SERVICE PROVIDER.

15 3. "Electric distribution service" means distributing electricity
16 to retail electric customers through the use of electric distribution
17 facilities.

18 4. "Electric generation service" means providing electricity for
19 sale to retail electric customers but excluding electric distribution or
20 transmission services.

21 5. "Electric transmission service" means transmitting electricity
22 to retail electric customers or to electric distribution facilities so
23 classified by the federal energy regulatory commission or, to the extent
24 permitted by law, so classified by the Arizona corporation commission.

25 6. "Other services" includes metering, meter reading services,
26 billing and collecting services.

27 7. "Retail electric customer" means a person who purchases
28 electricity for that person's own use, including use in that person's
29 trade or business and not for resale, redistribution or retransmission.

30 8. "Utility pole" means any wooden, metal or other pole used for
31 utility purposes and the pole's appurtenances that are attached or
32 authorized for attachment by the person controlling the pole.

33 Sec. 20. Section 42-5064, Arizona Revised Statutes, is amended to
34 read:

35 42-5064. Telecommunications classification; definitions

36 A. The telecommunications classification is comprised of the
37 business of providing intrastate telecommunications services. The
38 telecommunications classification does not include:

39 1. Sales of intrastate telecommunications services by a cable
40 operator or by a microwave television transmission system that transmits
41 television programming to multiple subscribers and that is operated
42 pursuant to 47 Code of Federal Regulations parts 21 and 74.

43 2. Sales of internet access or application services to the person's
44 subscribers and customers. For the purposes of this paragraph:

1 (a) "Application services" means software applications provided
2 remotely using hypertext transfer protocol or another network protocol and
3 purchased by or for any school district, charter school, community college
4 or state university to assess or test student learning or to promote
5 curriculum design or enhancement.

6 (b) "Curriculum design or enhancement" means planning, implementing
7 or reporting on courses of study, lessons, assignments or other learning
8 activities.

9 3. The leasing or renting of space to make attachments to utility
10 poles as follows:

11 (a) By a person that is engaged in business under this section.

12 (b) To a person that is engaged in business under section 42-5063
13 or this section or that is a cable operator.

14 B. The tax base for the telecommunications classification is the
15 gross proceeds of sales or gross income derived from the business,
16 including the gross income derived from tolls, subscriptions and services
17 on behalf of subscribers or from the publication of a directory of the
18 names of subscribers. However, the gross proceeds of sales or gross
19 income derived from the following shall be deducted from the tax base:

20 1. Sales of intrastate telecommunications services to:

21 (a) Other persons engaged in businesses classified under the
22 telecommunications classification for use in such business.

23 (b) A direct broadcast satellite television or data transmission
24 service that operates pursuant to 47 Code of Federal Regulations part 25
25 for use in its direct broadcast satellite television or data transmission
26 operation by a facility described in section 42-5061, subsection B,
27 paragraph 15, subdivision (b).

28 2. End user common line charges established by federal
29 communications commission regulations (47 Code of Federal Regulations
30 section 69.104(a)).

31 3. Carrier access charges established by federal communications
32 commission regulations (47 Code of Federal Regulations sections 69.105(a)
33 through 69.118).

34 4. Sales of direct broadcast satellite television services pursuant
35 to 47 Code of Federal Regulations part 25 by a direct broadcast satellite
36 television service that operates pursuant to 47 Code of Federal
37 Regulations part 25.

38 5. Telecommunications services purchased with a prepaid calling
39 card, or a prepaid authorization number for telecommunications services,
40 that is taxable under section 42-5061.

41 C. A person that is engaged in a transient lodging business subject
42 to taxation under section 42-5070 and that provides telephone, fax or
43 internet access services to its customers at an additional charge, which
44 is separately stated on the customer invoice, is considered to be engaged
45 in business subject to taxation under this section for the purposes of

1 taxing the gross proceeds of sales or gross income derived from providing
2 those services.

3 D. The gross proceeds of sales or gross income derived from a
4 bundled transaction of services that are taxable pursuant to section
5 42-5023 are subject to the following:

6 1. A telecommunications service provider who can reasonably
7 identify the portion of the sales price of the bundled transaction derived
8 from charges for nontaxable services is subject to tax only on the gross
9 proceeds of sales or gross income derived from the taxable services. For
10 the purposes of this section, the telecommunications service provider may
11 elect to reasonably identify the portion of the sales price of the bundled
12 transaction derived from charges for nontaxable services by using
13 allocation percentages derived from the telecommunications service
14 provider's entire service area, including territories outside of this
15 state. On request, the department may require the telecommunications
16 service provider to provide this allocation information. The
17 reasonableness of the allocation is subject to audit by the department.

18 2. Notwithstanding sections 42-1118, 42-1120 and 42-1121, the
19 telecommunications service provider shall waive the right to file a claim
20 for a refund of taxes paid on the bundled transaction if the taxes paid
21 are based on the allocation percentage the telecommunications service
22 provider had determined to be reasonable at the beginning of the tax
23 period at issue.

24 3. The burden of proof is on the telecommunications service
25 provider to establish that the gross proceeds of sales or gross income is
26 derived from charges for nontaxable services.

27 E. For the purposes of this section:

28 1. "Bundled transaction" means a sale of multiple services in which
29 both of the following apply:

30 (a) The sale consists of both taxable and nontaxable services.

31 (b) The telecommunications service provider charges a customer one
32 sales price for all services that are sold instead of separately charging
33 for each individual service.

34 2. "Cable operator" has the same meaning prescribed in section
35 9-505 **AND INCLUDES A VIDEO SERVICE PROVIDER.**

36 3. "Internet" means the computer and telecommunications facilities
37 that comprise the interconnected worldwide network of networks that employ
38 the transmission control protocol or internet protocol, or any predecessor
39 or successor protocol, to communicate information of all kinds by wire or
40 radio.

41 4. "Internet access" means a service that enables users to access
42 content, information, ~~electronic mail~~ **E-MAIL** or other services over the
43 internet. Internet access does not include telecommunications services
44 provided by a common carrier.

1 5. "Intrastate telecommunications services" means transmitting
2 signs, signals, writings, images, sounds, messages, data or other
3 information of any nature by wire, radio waves, light waves or other
4 electromagnetic means if the information transmitted originates and
5 terminates in this state.

6 6. "Utility pole" means any wooden, metal or other pole used for
7 utility purposes and the pole's appurtenances that are attached or
8 authorized for attachment by the person controlling the pole.

9 Sec. 21. Section 42-5069, Arizona Revised Statutes, is amended to
10 read:

11 42-5069. Commercial lease classification; definitions

12 A. The commercial lease classification is comprised of the business
13 of leasing for a consideration the use or occupancy of real property.

14 B. A person who, as a lessor, leases or rents for a consideration
15 under one or more leases or rental agreements the use or occupancy of real
16 property that is used by the lessee for commercial purposes is deemed to
17 be engaged in business and subject to the tax imposed by article 1 of this
18 chapter, but this subsection does not include leases or rentals of real
19 property used for residential or agricultural purposes.

20 C. The commercial lease classification does not include:

21 1. Any business activities that are classified under the transient
22 lodging classification.

23 2. Activities engaged in by the Arizona exposition and state fair
24 board or county fair commissions in connection with events sponsored by
25 those entities.

26 3. Leasing real property to a lessee who subleases the property if
27 the lessee is engaged in business classified under the commercial lease
28 classification or the transient lodging classification.

29 4. Leasing real property pursuant to a written lease agreement
30 entered into before December 1, 1967. This exclusion does not apply to
31 the businesses of hotels, guest houses, dude ranches and resorts, rooming
32 houses, apartment houses, office buildings, automobile storage garages,
33 parking lots or tourist camps, or to the extension or renewal of any such
34 written lease agreement.

35 5. Leasing real property between affiliated companies, businesses,
36 persons or reciprocal insurers. For the purposes of this paragraph:

37 (a) "Affiliated companies, businesses, persons or reciprocal
38 insurers" means the lessor holds a controlling interest in the lessee, the
39 lessee holds a controlling interest in the lessor, affiliated persons hold
40 a controlling interest in both the lessor and the lessee, or an unrelated
41 person holds a controlling interest in both the lessor and lessee.

42 (b) "Affiliated persons" means members of an individual's family or
43 persons who have ownership or control of a business entity.

1 (c) "Controlling interest" means direct or indirect ownership of at
2 least eighty percent of the voting shares of a corporation or of the
3 interests in a company, business or person other than a corporation.

4 (d) "Members of an individual's family" means the individual's
5 spouse and brothers and sisters, whether by whole or half blood, including
6 adopted persons, ancestors and lineal descendants.

7 (e) "Reciprocal insurers" has the same meaning prescribed in
8 section 20-762.

9 6. Leasing real property for boarding horses.

10 7. Leasing or renting real property or the right to use real
11 property at exhibition events in this state sponsored, operated or
12 conducted by a nonprofit organization that is exempt from taxation under
13 section 501(c)(3), 501(c)(4) or 501(c)(6) of the internal revenue code if
14 the organization is associated with major league baseball teams or a
15 national touring professional golfing association and no part of the
16 organization's net earnings inures to the benefit of any private
17 shareholder or individual. This paragraph does not apply to an
18 organization that is owned, managed or controlled, in whole or in part, by
19 a major league baseball team, or its owners, officers, employees or
20 agents, or by a major league baseball association or professional golfing
21 association, or its owners, officers, employees or agents, unless the
22 organization conducted or operated exhibition events in this state before
23 January 1, 2018 that were exempt from taxation under section 42-5073.

24 8. Leasing or renting real property or the right to use real
25 property for use as a rodeo featuring primarily farm and ranch animals in
26 this state sponsored, operated or conducted by a nonprofit organization
27 that is exempt from taxation under section 501(c)(3), 501(c)(4),
28 501(c)(6), 501(c)(7) or 501(c)(8) of the internal revenue code and no part
29 of the organization's net earnings inures to the benefit of any private
30 shareholder or individual.

31 9. Leasing or renting dwelling units, lodging facilities or trailer
32 or mobile home spaces if the units, facilities or spaces are intended to
33 serve as the principal or permanent place of residence for the lessee or
34 renter or if the unit, facility or space is leased or rented to a single
35 tenant thirty or more consecutive days.

36 10. Leasing or renting real property and improvements for use
37 primarily for religious worship by a nonprofit organization that is exempt
38 from taxation under section 501(c)(3) of the internal revenue code and no
39 part of the organization's net earnings inures to the benefit of any
40 private shareholder or individual.

41 11. Leasing or renting real property used for agricultural purposes
42 under either of the following circumstances:

43 (a) The lease or rental is between family members, trusts, estates,
44 corporations, partnerships, joint venturers or similar entities, or any
45 combination thereof, if the individuals or at least eighty percent of the

1 beneficiaries, shareholders, partners or joint venturers share a family
2 relationship as parents or ancestors of parents, children or descendants
3 of children, siblings, cousins of the first degree, aunts, uncles, nieces
4 or nephews of the first degree, spouses of any of the listed relatives and
5 listed relatives by the half-blood or by adoption.

6 (b) The lessor leases or rents real property used for agricultural
7 purposes under no more than three leases or rental agreements.

8 12. Leasing, renting or granting the right to use real property to
9 vendors or exhibitors by a trade or industry association that is a
10 qualifying organization pursuant to section 513(d)(3)(C) of the internal
11 revenue code for a period not to exceed twenty-one days in connection with
12 an event that meets all of the following conditions:

13 (a) The majority of such vending or exhibition activities relate to
14 the nature of the trade or business sponsoring the event.

15 (b) The event is held in conjunction with a formal business meeting
16 of the trade or industry association.

17 (c) The event is organized by the persons engaged in the particular
18 trade or industry.

19 13. Leasing, renting or granting the right to use real property for
20 a period not to exceed twenty-one days by a coliseum, civic center, civic
21 plaza, convention center, auditorium or arena owned by this state or any
22 of its political subdivisions.

23 14. Leasing or subleasing real property used by a nursing care
24 institution as defined in section 36-401 that is licensed pursuant to
25 title 36, chapter 4.

26 15. Leasing or renting an eligible facility as defined in section
27 28-7701.

28 16. Granting or providing rights to real property that constitute a
29 profit à prendre for the severance of minerals, including all rights to
30 use the surface or subsurface of the property as is necessary or
31 convenient to the right to sever the minerals. This paragraph does not
32 exclude from the commercial lease classification leasehold rights to the
33 real property that are granted in addition to and not included within the
34 right of profit à prendre, but the tax base for the grant of such a
35 leasehold right, if the gross income derived from the grant is not
36 separately stated from the gross income derived from the grant of the
37 profit à prendre, shall not exceed the fair market value of the leasehold
38 rights computed after excluding the value of all rights under the profit à
39 prendre. For the purposes of this paragraph, "profit à prendre" means a
40 right to use the land of another to mine minerals, and carries with it the
41 right of entry and the right to remove and take the minerals from the land
42 and also includes the right to use the surface of the land as is necessary
43 and convenient for exercise of the profit.

1 17. The leasing or renting of space to make attachments to utility
2 poles as follows:

3 (a) By a person that is engaged in business under section 42-5063
4 or 42-5064 or that is a cable operator.

5 (b) To a person that is engaged in business under section 42-5063
6 or 42-5064 or that is a cable operator.

7 D. The tax base for the commercial lease classification is the
8 gross proceeds of sales or gross income derived from the business, but
9 reimbursements to the lessor for utility service shall be deducted from
10 the tax base.

11 E. Notwithstanding section 42-1104, subsection B, paragraph 1,
12 subdivision (b) and paragraph 2, the failure to file tax returns for the
13 commercial lease classification that report gross income derived from any
14 agreement that constitutes, in whole or in part, a grant of a right of
15 profit à prendre for the severance of minerals does not constitute an
16 exception to the general rule for the statute of limitations.

17 F. For the purposes of this section:

18 1. "Cable operator" has the same meaning prescribed in section
19 9-505 **AND INCLUDES A VIDEO SERVICE PROVIDER.**

20 2. "Leasing" includes renting.

21 3. "Real property" includes any improvements, rights or interest in
22 such property.

23 4. "Utility pole" means any wooden, metal or other pole used for
24 utility purposes and the pole's appurtenances that are attached or
25 authorized for attachment by the person controlling the pole.

26 Sec. 22. Section 42-5071, Arizona Revised Statutes, is amended to
27 read:

28 **42-5071. Personal property rental classification; definitions**

29 A. The personal property rental classification is comprised of the
30 business of leasing or renting tangible personal property for a
31 consideration. The tax does not apply to:

32 1. Leasing or renting films, tapes or slides used by theaters or
33 movies, which are engaged in business under the amusement classification,
34 or used by television stations or radio stations.

35 2. Activities engaged in by the Arizona exposition and state fair
36 board or county fair commissions in connection with events sponsored by
37 such entities.

38 3. Leasing or renting tangible personal property by a parent
39 corporation to a subsidiary corporation or by a subsidiary corporation to
40 another subsidiary of the same parent corporation if taxes were paid under
41 this chapter on the gross proceeds or gross income accruing from the
42 initial sale of the tangible personal property. For the purposes of this
43 paragraph, "subsidiary" means a corporation of which at least eighty
44 percent of the voting shares are owned by the parent corporation.

1 4. Operating coin-operated washing, drying and dry cleaning
2 machines or coin-operated car washing machines at establishments for the
3 use of such machines.

4 5. Leasing or renting tangible personal property for incorporation
5 into or comprising any part of a qualified environmental technology
6 facility as described in section 41-1514.02. This paragraph shall apply
7 for ten full consecutive calendar or fiscal years following the initial
8 lease or rental by each qualified environmental technology manufacturer,
9 producer or processor.

10 6. Leasing or renting aircraft, flight simulators or similar
11 training equipment to students or staff by nonprofit, accredited
12 educational institutions that offer associate or baccalaureate degrees in
13 aviation or aerospace related fields.

14 7. Leasing or renting photographs, transparencies or other creative
15 works used by this state on internet websites, in magazines or in other
16 publications that encourage tourism.

17 8. Leasing or renting certified ignition interlock devices
18 installed pursuant to the requirements prescribed by section 28-1461. For
19 the purposes of this paragraph, "certified ignition interlock device" has
20 the same meaning prescribed in section 28-1301.

21 9. The leasing or renting of space to make attachments to utility
22 poles, as follows:

23 (a) By a person that is engaged in business under section 42-5063
24 or 42-5064 or that is a cable operator.

25 (b) To a person that is engaged in business under section 42-5063
26 or 42-5064 or that is a cable operator.

27 10. Leasing or renting billboards that are designed, intended or
28 used to advertise or inform and that are visible from any street, road or
29 other highway.

30 B. The tax base for the personal property rental classification is
31 the gross proceeds of sales or gross income derived from the business, but
32 the gross proceeds of sales or gross income derived from the following
33 shall be deducted from the tax base:

34 1. Reimbursements by the lessee to the lessor of a motor vehicle
35 for payments by the lessor of the applicable fees and taxes imposed by
36 sections 28-2003, 28-2352, 28-2402, 28-2481 and 28-5801, title 28, chapter
37 15, article 2 and article IX, section 11, Constitution of Arizona, to the
38 extent such amounts are separately identified as such fees and taxes and
39 are billed to the lessee.

40 2. Leases or rentals of tangible personal property that, if it had
41 been purchased instead of leased or rented by the lessee, would have been
42 exempt under:

43 (a) Section 42-5061, subsection A, paragraph 8, 9, 12, 13, 25, 29,
44 49 or 53.

1 (b) Section 42-5061, subsection B, except that a lease or rental of
2 new machinery or equipment is not exempt pursuant to section 42-5061,
3 subsection B, paragraph 13 if the lease is for less than two years.

4 (c) Section 42-5061, subsection I, paragraph 1.

5 (d) Section 42-5061, subsection M.

6 3. Motor vehicle fuel and use fuel that are subject to a tax
7 imposed under title 28, chapter 16, article 1, sales of use fuel to a
8 holder of a valid single trip use fuel tax permit issued under section
9 28-5739 and sales of aviation fuel that are subject to the tax imposed
10 under section 28-8344.

11 4. Leasing or renting a motor vehicle subject to and on which the
12 fee has been paid under title 28, chapter 16, article 4.

13 5. Amounts received by a motor vehicle dealer for the first month
14 of a lease payment if the lease and the lease payment for the first month
15 of the lease are transferred to a third-party leasing company.

16 C. Sales of tangible personal property to be leased or rented to a
17 person engaged in a business classified under the personal property rental
18 classification are deemed to be resale sales.

19 D. In computing the tax base, the gross proceeds of sales or gross
20 income from the lease or rental of a motor vehicle does not include any
21 amount attributable to the car rental surcharge under section 5-839,
22 28-5810 or 48-4234.

23 E. Until December 31, 1988, leasing or renting animals for
24 recreational purposes is exempt from the tax imposed by this section.
25 Beginning January 1, 1989, the gross proceeds or gross income from leasing
26 or renting animals for recreational purposes is subject to taxation under
27 this section. Tax liabilities, penalties and interest paid for taxable
28 periods before January 1, 1989 shall not be refunded unless the taxpayer
29 requesting the refund provides proof satisfactory to the department that
30 the monies paid as taxes will be returned to the customer.

31 F. For the purposes of this section:

32 1. "Cable operator" has the same meaning prescribed by section
33 9-505 AND INCLUDES A VIDEO SERVICE PROVIDER.

34 2. "Utility pole" means any wooden, metal or other pole used for
35 utility purposes and the pole's appurtenances that are attached or
36 authorized for attachment by the person controlling the pole.

37 Sec. 23. Section 42-6004, Arizona Revised Statutes, as amended by
38 Laws 2018, chapter 17, section 1, chapter 249, section 6 and chapter 341,
39 section 2, is amended to read:

40 42-6004. Exemption from municipal tax; definitions

41 A. A city, town or special taxing district shall not levy a
42 transaction privilege, sales, use or other similar tax on:

43 1. Exhibition events in this state sponsored, conducted or operated
44 by a nonprofit organization that is exempt from taxation under section
45 501(c)(3), 501(c)(4) or 501(c)(6) of the internal revenue code if the

1 organization is associated with a major league baseball team or a national
2 touring professional golfing association and no part of the organization's
3 net earnings inures to the benefit of any private shareholder or
4 individual. This paragraph does not apply to an organization that is
5 owned, managed or controlled, in whole or in part, by a major league
6 baseball team, or its owners, officers, employees or agents, or by a major
7 league baseball association or professional golfing association, or its
8 owners, officers, employees or agents, unless the organization conducted
9 or operated exhibition events in this state before January 1, 2018 that
10 were exempt from state transaction privilege tax under section 42-5073.

11 2. Interstate telecommunications services, which include that
12 portion of telecommunications services, such as subscriber line service,
13 allocable by federal law to interstate telecommunications service.

14 3. Sales of warranty or service contracts.

15 4. Sales of motor vehicles to nonresidents of this state for use
16 outside this state if the motor vehicle dealer ships or delivers the motor
17 vehicle to a destination outside this state.

18 5. Interest on finance contracts.

19 6. Dealer documentation fees on the sales of motor vehicles.

20 7. Orthodontic devices dispensed by a dental professional who is
21 licensed under title 32, chapter 11 to a patient as part of the practice
22 of dentistry.

23 8. Sales of internet access services to the person's subscribers
24 and customers. For the purposes of this paragraph:

25 (a) "Internet" means the computer and telecommunications facilities
26 that comprise the interconnected worldwide network of networks that employ
27 the transmission control protocol or internet protocol, or any predecessor
28 or successor protocol, to communicate information of all kinds by wire or
29 radio.

30 (b) "Internet access" means a service that enables users to access
31 content, information, electronic mail or other services over the internet.
32 Internet access does not include telecommunication services provided by a
33 common carrier.

34 9. The gross proceeds of sales or gross income retained by the
35 Arizona exposition and state fair board from ride ticket sales at the
36 annual Arizona state fair.

37 10. Leasing real property between affiliated companies, businesses,
38 persons or reciprocal insurers. For the purposes of this paragraph:

39 (a) "Affiliated companies, businesses, persons or reciprocal
40 insurers" means the lessor holds a controlling interest in the lessee, the
41 lessee holds a controlling interest in the lessor, affiliated persons hold
42 a controlling interest in both the lessor and the lessee, or an unrelated
43 person holds a controlling interest in both the lessor and lessee.

44 (b) "Affiliated persons" means members of the individual's family
45 or persons who have ownership or control of a business entity.

1 (c) "Controlling interest" means direct or indirect ownership of at
2 least eighty percent of the voting shares of a corporation or of the
3 interests in a company, business or person other than a corporation.

4 (d) "Members of the individual's family" means the individual's
5 spouse and brothers and sisters, whether by whole or half blood, including
6 adopted persons, ancestors and lineal descendants.

7 (e) "Reciprocal insurer" has the same meaning prescribed in section
8 20-762.

9 11. The gross proceeds of sales or gross income derived from a
10 contract for the installation, assembly, repair or maintenance of
11 machinery, equipment or other tangible personal property that is described
12 in section 42-5061, subsection B and that has independent functional
13 utility, pursuant to the following provisions:

14 (a) The deduction provided in this paragraph includes the gross
15 proceeds of sales or gross income derived from all of the following:

16 (i) Any activity performed on machinery, equipment or other
17 tangible personal property with independent functional utility.

18 (ii) Any activity performed on any tangible personal property
19 relating to machinery, equipment or other tangible personal property with
20 independent functional utility in furtherance of any of the purposes
21 provided for under subdivision (d) of this paragraph.

22 (iii) Any activity that is related to the activities described in
23 items (i) and (ii) of this subdivision, including inspecting the
24 installation of or testing the machinery, equipment or other tangible
25 personal property.

26 (b) The deduction provided in this paragraph does not include gross
27 proceeds of sales or gross income from the portion of any contracting
28 activity that consists of the development of, or modification to, real
29 property in order to facilitate the installation, assembly, repair,
30 maintenance or removal of machinery, equipment or other tangible personal
31 property described in section 42-5061, subsection B.

32 (c) The deduction provided in this paragraph shall be determined
33 without regard to the size or useful life of the machinery, equipment or
34 other tangible personal property.

35 (d) For the purposes of this paragraph, "independent functional
36 utility" means that the machinery, equipment or other tangible personal
37 property can independently perform its function without attachment to real
38 property, other than attachment for any of the following purposes:

39 (i) Assembling the machinery, equipment or other tangible personal
40 property.

41 (ii) Connecting items of machinery, equipment or other tangible
42 personal property to each other.

43 (iii) Connecting the machinery, equipment or other tangible
44 personal property, whether as an individual item or as a system of items,
45 to water, power, gas, communication or other services.

1 (iv) Stabilizing or protecting the machinery, equipment or other
2 tangible personal property during operation by bolting, burying or
3 performing other dissimilar nonpermanent connections to either real
4 property or real property improvements.

5 12. The leasing or renting of certified ignition interlock devices
6 installed pursuant to the requirements prescribed by section 28-1461. For
7 the purposes of this paragraph, "certified ignition interlock device" has
8 the same meaning prescribed in section 28-1301.

9 13. Computer data center equipment sold to the owner, operator or
10 qualified colocation tenant of a computer data center that is certified by
11 the Arizona commerce authority under section 41-1519 or an authorized
12 agent of the owner, operator or qualified colocation tenant during the
13 qualification period for use in the qualified computer data center. For
14 the purposes of this paragraph, "computer data center", "computer data
15 center equipment", "qualification period" and "qualified colocation
16 tenant" have the same meanings prescribed in section 41-1519.

17 14. The gross proceeds of sales or gross income derived from a
18 contract with the owner of real property or improvements to real property
19 for the maintenance, repair, replacement or alteration of existing
20 property, except as specified in this paragraph. The gross proceeds of
21 sales or gross income derived from a de minimis amount of modification
22 activity does not subject the contract or any part of the contract to tax.
23 For the purposes of this paragraph:

24 (a) Each contract is independent of another contract, except that
25 any change order that directly relates to the scope of work of the
26 original contract shall be treated the same as the original contract under
27 this paragraph, regardless of the amount of modification activities
28 included in the change order. If a change order does not directly relate
29 to the scope of work of the original contract, the change order shall be
30 treated as a new contract, with the tax treatment of any subsequent change
31 order to follow the tax treatment of the contract to which the scope of
32 work of the subsequent change order directly relates.

33 (b) Any term not defined in this paragraph that is defined in
34 section 42-5075 has the same meaning prescribed in section 42-5075.

35 (c) This paragraph does not apply to a contract that primarily
36 involves surface or subsurface improvements to land and that is subject to
37 title 28, chapter 19, 20 or 22 or title 34, chapter 2 or 6 even if the
38 contract also includes vertical improvements. If a city or town imposes a
39 tax on contracts that are subject to procurement processes under those
40 provisions, the city or town shall include in the request for proposals a
41 notice to bidders when those projects are subject to the tax. This
42 subdivision does not apply to contracts with:

43 (i) Community facilities districts, fire districts, county
44 television improvement districts, community park maintenance districts,
45 cotton pest control districts, hospital districts, pest abatement

1 districts, health service districts, agricultural improvement districts,
2 county free library districts, county jail districts, county stadium
3 districts, special health care districts, public health services
4 districts, theme park districts or revitalization districts.

5 (ii) Any special taxing district not specified in item (i) of this
6 subdivision if the district does not substantially engage in the
7 modification, maintenance, repair, replacement or alteration of surface or
8 subsurface improvements to land.

9 15. Monitoring services relating to an alarm system as defined in
10 section 32-101.

11 16. Tangible personal property, job printing or publications sold
12 to or purchased by, or tangible personal property leased, rented or
13 licensed for use to or by, a qualifying health sciences educational
14 institution as defined in section 42-5001.

15 17. The transfer of title or possession of coal back and forth
16 between an owner or operator of a power plant and a person who is
17 responsible for refining coal if both of the following apply:

18 (a) The transfer of title or possession of the coal is for the
19 purpose of refining the coal.

20 (b) The title or possession of the coal is transferred back to the
21 owner or operator of the power plant after completion of the coal refining
22 process. For the purposes of this subdivision, "coal refining process"
23 means the application of a coal additive system that aids the reduction of
24 power plant emissions during the combustion of coal and the treatment of
25 flue gas.

26 18. Tangible personal property incorporated or fabricated into a
27 project described in paragraph 14 of this subsection, that is located
28 within the exterior boundaries of an Indian reservation for which the
29 owner, as defined in section 42-5075, of the project is an Indian tribe or
30 an affiliated Indian. For the purposes of this paragraph:

31 (a) "Affiliated Indian" means an individual native American Indian
32 who is duly registered on the tribal rolls of the Indian tribe for whose
33 benefit the Indian reservation was established.

34 (b) "Indian reservation" means all lands that are within the limits
35 of areas set aside by the United States for the exclusive use and
36 occupancy of an Indian tribe by treaty, law or executive order and that
37 are recognized as Indian reservations by the United States department of
38 the interior.

39 (c) "Indian tribe" means any organized nation, tribe, band or
40 community that is recognized as an Indian tribe by the United States
41 department of the interior and includes any entity formed under the laws
42 of that Indian tribe.

43 19. The charges for the leasing or renting of space to make
44 attachments to utility poles as follows:

1 (a) By a person that is engaged in the business of providing or
2 furnishing electrical services or telecommunication services or that is a
3 cable operator.

4 (b) To a person that is engaged in the business of providing or
5 furnishing electrical services or telecommunication services or that is a
6 cable operator.

7 20. Until March 1, 2017, the gross proceeds of sales or gross
8 income derived from entry fees paid by participants for events that
9 consist of a run, walk, swim or bicycle ride or a similar event, or any
10 combination of these events.

11 21. The gross proceeds of sales or gross income derived from entry
12 fees paid by participants for events that are operated or conducted by
13 nonprofit organizations that are exempt from taxation under section
14 501(c)(3) of the internal revenue code and of which no part of the
15 organization's net earnings inures to the benefit of any private
16 shareholder or individual, if the event consists of a run, walk, swim or
17 bicycle ride or a similar event, or any combination of these events.

18 B. A city, town or other taxing jurisdiction shall not levy a
19 transaction privilege, sales, use, franchise or other similar tax or fee,
20 however denominated, on natural gas or liquefied petroleum gas used to
21 propel a motor vehicle.

22 C. A city, town or other taxing jurisdiction shall not levy a
23 transaction privilege, sales, gross receipts, use, franchise or other
24 similar tax or fee, however denominated, on gross proceeds of sales or
25 gross income derived from any of the following:

26 1. A motor carrier's use on the public highways in this state if
27 the motor carrier is subject to a fee prescribed in title 28, chapter 16,
28 article 4.

29 2. Leasing, renting or licensing a motor vehicle subject to and on
30 which the fee has been paid under title 28, chapter 16, article 4.

31 3. The sale of a motor vehicle and any repair and replacement parts
32 and tangible personal property becoming a part of such motor vehicle to a
33 motor carrier who is subject to a fee prescribed in title 28, chapter 16,
34 article 4 and who is engaged in the business of leasing, renting or
35 licensing such property.

36 4. Incarcerating or detaining in a privately operated prison, jail
37 or detention facility prisoners who are under the jurisdiction of the
38 United States, this state or any other state or a political subdivision of
39 this state or of any other state.

40 5. Transporting for hire persons, freight or property by light
41 motor vehicles subject to a fee under title 28, chapter 15, article 4.

42 6. Any amount attributable to development fees that are incurred in
43 relation to the construction, development or improvement of real property
44 and paid by the taxpayer as defined in the model city tax code or by a

1 contractor providing services to the taxpayer. For the purposes of this
2 paragraph:

3 (a) The attributable amount shall not exceed the value of the
4 development fees actually imposed.

5 (b) The attributable amount is equal to the total amount of
6 development fees paid by the taxpayer or by a contractor providing
7 services to the taxpayer and the total development fees credited in
8 exchange for the construction of, contribution to or dedication of real
9 property for providing public infrastructure, public safety or other
10 public services necessary to the development. The real property must be
11 the subject of the development fees.

12 (c) "Development fees" means fees imposed to offset capital costs
13 of providing public infrastructure, public safety or other public services
14 to a development and authorized pursuant to section 9-463.05, section
15 11-1102 or title 48 regardless of the jurisdiction to which the fees are
16 paid.

17 7. Any amount attributable to fees collected by transportation
18 network companies issued a permit pursuant to section 28-9552.

19 8. Transporting for hire persons by transportation network company
20 drivers on transactions involving transportation network services as
21 defined in section 28-9551.

22 9. Transporting for hire persons by vehicle for hire companies that
23 are issued permits pursuant to section 28-9503.

24 10. Transporting for hire persons by vehicle for hire drivers on
25 transactions involving vehicle for hire services as defined in section
26 28-9501.

27 D. A city, town or other taxing jurisdiction shall not levy a
28 transaction privilege, sales, use, franchise or other similar tax or fee,
29 however denominated, in excess of one-tenth of one percent of the value of
30 the entire product mined, smelted, extracted, refined, produced or
31 prepared for sale, profit or commercial use, on persons engaged in the
32 business of mineral processing, except to the extent that the tax is
33 computed on the gross proceeds or gross income from sales at retail.

34 E. In computing the tax base, any city, town or other taxing
35 jurisdiction shall not include in the gross proceeds of sales or gross
36 income:

37 1. A manufacturer's cash rebate on the sales price of a motor
38 vehicle if the buyer assigns the buyer's right in the rebate to the
39 retailer.

40 2. The waste tire disposal fee imposed pursuant to section 44-1302.

41 F. A city or town shall not levy a use tax on the storage, use or
42 consumption of tangible personal property in the city or town by a school
43 district or charter school.

1 G. For the purposes of this section:

2 1. "Cable operator" has the same meaning prescribed in section
3 9-505 **AND INCLUDES A VIDEO SERVICE PROVIDER.**

4 2. "Electrical services" means transmitting or distributing
5 electricity, electric lights, current or power over lines, wires or
6 cables.

7 3. "Telecommunication services" means transmitting or relaying
8 sound, visual image, data, information, images or material over lines,
9 wires or cables by radio signal, light beam, telephone, telegraph or other
10 electromagnetic means.

11 4. "Utility pole" means any wooden, metal or other pole used for
12 utility purposes and the pole's appurtenances that are attached or
13 authorized for attachment by the person controlling the pole.

14 Sec. 24. Section 42-6004, Arizona Revised Statutes, as amended by
15 Laws 2018, chapter 17, section 1, chapter 249, section 6, chapter 263,
16 section 3 and chapter 341, section 2, is amended to read:

17 **42-6004. Exemption from municipal tax; definitions**

18 A. A city, town or special taxing district shall not levy a
19 transaction privilege, sales, use or other similar tax on:

20 1. Exhibition events in this state sponsored, conducted or operated
21 by a nonprofit organization that is exempt from taxation under section
22 501(c)(3), 501(c)(4) or 501(c)(6) of the internal revenue code if the
23 organization is associated with a major league baseball team or a national
24 touring professional golfing association and no part of the organization's
25 net earnings inures to the benefit of any private shareholder or
26 individual. This paragraph does not apply to an organization that is
27 owned, managed or controlled, in whole or in part, by a major league
28 baseball team, or its owners, officers, employees or agents, or by a major
29 league baseball association or professional golfing association, or its
30 owners, officers, employees or agents, unless the organization conducted
31 or operated exhibition events in this state before January 1, 2018 that
32 were exempt from state transaction privilege tax under section 42-5073.

33 2. Interstate telecommunications services, which include that
34 portion of telecommunications services, such as subscriber line service,
35 allocable by federal law to interstate telecommunications service.

36 3. Sales of warranty or service contracts.

37 4. Sales of motor vehicles to nonresidents of this state for use
38 outside this state if the motor vehicle dealer ships or delivers the motor
39 vehicle to a destination outside this state.

40 5. Interest on finance contracts.

41 6. Dealer documentation fees on the sales of motor vehicles.

42 7. Orthodontic devices dispensed by a dental professional who is
43 licensed under title 32, chapter 11 to a patient as part of the practice
44 of dentistry.

1 8. Sales of internet access services to the person's subscribers
2 and customers. For the purposes of this paragraph:

3 (a) "Internet" means the computer and telecommunications facilities
4 that comprise the interconnected worldwide network of networks that employ
5 the transmission control protocol or internet protocol, or any predecessor
6 or successor protocol, to communicate information of all kinds by wire or
7 radio.

8 (b) "Internet access" means a service that enables users to access
9 content, information, electronic mail or other services over the internet.
10 Internet access does not include telecommunication services provided by a
11 common carrier.

12 9. The gross proceeds of sales or gross income retained by the
13 Arizona exposition and state fair board from ride ticket sales at the
14 annual Arizona state fair.

15 10. Leasing real property between affiliated companies, businesses,
16 persons or reciprocal insurers. For the purposes of this paragraph:

17 (a) "Affiliated companies, businesses, persons or reciprocal
18 insurers" means the lessor holds a controlling interest in the lessee, the
19 lessee holds a controlling interest in the lessor, affiliated persons hold
20 a controlling interest in both the lessor and the lessee, or an unrelated
21 person holds a controlling interest in both the lessor and lessee.

22 (b) "Affiliated persons" means members of the individual's family
23 or persons who have ownership or control of a business entity.

24 (c) "Controlling interest" means direct or indirect ownership of at
25 least eighty percent of the voting shares of a corporation or of the
26 interests in a company, business or person other than a corporation.

27 (d) "Members of the individual's family" means the individual's
28 spouse and brothers and sisters, whether by whole or half blood, including
29 adopted persons, ancestors and lineal descendants.

30 (e) "Reciprocal insurer" has the same meaning prescribed in section
31 20-762.

32 11. The gross proceeds of sales or gross income derived from a
33 contract for the installation, assembly, repair or maintenance of
34 machinery, equipment or other tangible personal property that is described
35 in section 42-5061, subsection B and that has independent functional
36 utility, pursuant to the following provisions:

37 (a) The deduction provided in this paragraph includes the gross
38 proceeds of sales or gross income derived from all of the following:

39 (i) Any activity performed on machinery, equipment or other
40 tangible personal property with independent functional utility.

41 (ii) Any activity performed on any tangible personal property
42 relating to machinery, equipment or other tangible personal property with
43 independent functional utility in furtherance of any of the purposes
44 provided for under subdivision (d) of this paragraph.

1 (iii) Any activity that is related to the activities described in
2 items (i) and (ii) of this subdivision, including inspecting the
3 installation of or testing the machinery, equipment or other tangible
4 personal property.

5 (b) The deduction provided in this paragraph does not include gross
6 proceeds of sales or gross income from the portion of any contracting
7 activity that consists of the development of, or modification to, real
8 property in order to facilitate the installation, assembly, repair,
9 maintenance or removal of machinery, equipment or other tangible personal
10 property described in section 42-5061, subsection B.

11 (c) The deduction provided in this paragraph shall be determined
12 without regard to the size or useful life of the machinery, equipment or
13 other tangible personal property.

14 (d) For the purposes of this paragraph, "independent functional
15 utility" means that the machinery, equipment or other tangible personal
16 property can independently perform its function without attachment to real
17 property, other than attachment for any of the following purposes:

18 (i) Assembling the machinery, equipment or other tangible personal
19 property.

20 (ii) Connecting items of machinery, equipment or other tangible
21 personal property to each other.

22 (iii) Connecting the machinery, equipment or other tangible
23 personal property, whether as an individual item or as a system of items,
24 to water, power, gas, communication or other services.

25 (iv) Stabilizing or protecting the machinery, equipment or other
26 tangible personal property during operation by bolting, burying or
27 performing other dissimilar nonpermanent connections to either real
28 property or real property improvements.

29 12. The leasing or renting of certified ignition interlock devices
30 installed pursuant to the requirements prescribed by section 28-1461. For
31 the purposes of this paragraph, "certified ignition interlock device" has
32 the same meaning prescribed in section 28-1301.

33 13. Computer data center equipment sold to the owner, operator or
34 qualified colocation tenant of a computer data center that is certified by
35 the Arizona commerce authority under section 41-1519 or an authorized
36 agent of the owner, operator or qualified colocation tenant during the
37 qualification period for use in the qualified computer data center. For
38 the purposes of this paragraph, "computer data center", "computer data
39 center equipment", "qualification period" and "qualified colocation
40 tenant" have the same meanings prescribed in section 41-1519.

41 14. The gross proceeds of sales or gross income derived from a
42 contract with the owner of real property or improvements to real property
43 for the maintenance, repair, replacement or alteration of existing
44 property, except as specified in this paragraph. The gross proceeds of
45 sales or gross income derived from a de minimis amount of modification

1 activity does not subject the contract or any part of the contract to tax.
2 For the purposes of this paragraph:

3 (a) Each contract is independent of another contract, except that
4 any change order that directly relates to the scope of work of the
5 original contract shall be treated the same as the original contract under
6 this paragraph, regardless of the amount of modification activities
7 included in the change order. If a change order does not directly relate
8 to the scope of work of the original contract, the change order shall be
9 treated as a new contract, with the tax treatment of any subsequent change
10 order to follow the tax treatment of the contract to which the scope of
11 work of the subsequent change order directly relates.

12 (b) Any term not defined in this paragraph that is defined in
13 section 42-5075 has the same meaning prescribed in section 42-5075.

14 (c) This paragraph does not apply to a contract that primarily
15 involves surface or subsurface improvements to land and that is subject to
16 title 28, chapter 19, 20 or 22 or title 34, chapter 2 or 6 even if the
17 contract also includes vertical improvements. If a city or town imposes a
18 tax on contracts that are subject to procurement processes under those
19 provisions, the city or town shall include in the request for proposals a
20 notice to bidders when those projects are subject to the tax. This
21 subdivision does not apply to contracts with:

22 (i) Community facilities districts, fire districts, county
23 television improvement districts, community park maintenance districts,
24 cotton pest control districts, hospital districts, pest abatement
25 districts, health service districts, agricultural improvement districts,
26 county free library districts, county jail districts, county stadium
27 districts, special health care districts, public health services
28 districts, theme park districts or revitalization districts.

29 (ii) Any special taxing district not specified in item (i) of this
30 subdivision if the district does not substantially engage in the
31 modification, maintenance, repair, replacement or alteration of surface or
32 subsurface improvements to land.

33 15. Monitoring services relating to an alarm system as defined in
34 section 32-101.

35 16. Tangible personal property, job printing or publications sold
36 to or purchased by, or tangible personal property leased, rented or
37 licensed for use to or by, a qualifying health sciences educational
38 institution as defined in section 42-5001.

39 17. The sale of coal.

40 18. Tangible personal property incorporated or fabricated into a
41 project described in paragraph 14 of this subsection, that is located
42 within the exterior boundaries of an Indian reservation for which the
43 owner, as defined in section 42-5075, of the project is an Indian tribe or
44 an affiliated Indian. For the purposes of this paragraph:

1 (a) "Affiliated Indian" means an individual native American Indian
2 who is duly registered on the tribal rolls of the Indian tribe for whose
3 benefit the Indian reservation was established.

4 (b) "Indian reservation" means all lands that are within the limits
5 of areas set aside by the United States for the exclusive use and
6 occupancy of an Indian tribe by treaty, law or executive order and that
7 are recognized as Indian reservations by the United States department of
8 the interior.

9 (c) "Indian tribe" means any organized nation, tribe, band or
10 community that is recognized as an Indian tribe by the United States
11 department of the interior and includes any entity formed under the laws
12 of that Indian tribe.

13 19. The charges for the leasing or renting of space to make
14 attachments to utility poles as follows:

15 (a) By a person that is engaged in the business of providing or
16 furnishing electrical services or telecommunication services or that is a
17 cable operator.

18 (b) To a person that is engaged in the business of providing or
19 furnishing electrical services or telecommunication services or that is a
20 cable operator.

21 20. Until March 1, 2017, the gross proceeds of sales or gross
22 income derived from entry fees paid by participants for events that
23 consist of a run, walk, swim or bicycle ride or a similar event, or any
24 combination of these events.

25 21. The gross proceeds of sales or gross income derived from entry
26 fees paid by participants for events that are operated or conducted by
27 nonprofit organizations that are exempt from taxation under section
28 501(c)(3) of the internal revenue code and of which no part of the
29 organization's net earnings inures to the benefit of any private
30 shareholder or individual, if the event consists of a run, walk, swim or
31 bicycle ride or a similar event, or any combination of these events.

32 B. A city, town or other taxing jurisdiction shall not levy a
33 transaction privilege, sales, use, franchise or other similar tax or fee,
34 however denominated, on natural gas or liquefied petroleum gas used to
35 propel a motor vehicle.

36 C. A city, town or other taxing jurisdiction shall not levy a
37 transaction privilege, sales, gross receipts, use, franchise or other
38 similar tax or fee, however denominated, on gross proceeds of sales or
39 gross income derived from any of the following:

40 1. A motor carrier's use on the public highways in this state if
41 the motor carrier is subject to a fee prescribed in title 28, chapter 16,
42 article 4.

43 2. Leasing, renting or licensing a motor vehicle subject to and on
44 which the fee has been paid under title 28, chapter 16, article 4.

1 3. The sale of a motor vehicle and any repair and replacement parts
2 and tangible personal property becoming a part of such motor vehicle to a
3 motor carrier who is subject to a fee prescribed in title 28, chapter 16,
4 article 4 and who is engaged in the business of leasing, renting or
5 licensing such property.

6 4. Incarcerating or detaining in a privately operated prison, jail
7 or detention facility prisoners who are under the jurisdiction of the
8 United States, this state or any other state or a political subdivision of
9 this state or of any other state.

10 5. Transporting for hire persons, freight or property by light
11 motor vehicles subject to a fee under title 28, chapter 15, article 4.

12 6. Any amount attributable to development fees that are incurred in
13 relation to the construction, development or improvement of real property
14 and paid by the taxpayer as defined in the model city tax code or by a
15 contractor providing services to the taxpayer. For the purposes of this
16 paragraph:

17 (a) The attributable amount shall not exceed the value of the
18 development fees actually imposed.

19 (b) The attributable amount is equal to the total amount of
20 development fees paid by the taxpayer or by a contractor providing
21 services to the taxpayer and the total development fees credited in
22 exchange for the construction of, contribution to or dedication of real
23 property for providing public infrastructure, public safety or other
24 public services necessary to the development. The real property must be
25 the subject of the development fees.

26 (c) "Development fees" means fees imposed to offset capital costs
27 of providing public infrastructure, public safety or other public services
28 to a development and authorized pursuant to section 9-463.05, section
29 11-1102 or title 48 regardless of the jurisdiction to which the fees are
30 paid.

31 7. Any amount attributable to fees collected by transportation
32 network companies issued a permit pursuant to section 28-9552.

33 8. Transporting for hire persons by transportation network company
34 drivers on transactions involving transportation network services as
35 defined in section 28-9551.

36 9. Transporting for hire persons by vehicle for hire companies that
37 are issued permits pursuant to section 28-9503.

38 10. Transporting for hire persons by vehicle for hire drivers on
39 transactions involving vehicle for hire services as defined in section
40 28-9501.

41 D. A city, town or other taxing jurisdiction shall not levy a
42 transaction privilege, sales, use, franchise or other similar tax or fee,
43 however denominated, in excess of one-tenth of one percent of the value of
44 the entire product mined, smelted, extracted, refined, produced or
45 prepared for sale, profit or commercial use, on persons engaged in the

1 business of mineral processing, except to the extent that the tax is
2 computed on the gross proceeds or gross income from sales at retail.

3 E. In computing the tax base, any city, town or other taxing
4 jurisdiction shall not include in the gross proceeds of sales or gross
5 income:

6 1. A manufacturer's cash rebate on the sales price of a motor
7 vehicle if the buyer assigns the buyer's right in the rebate to the
8 retailer.

9 2. The waste tire disposal fee imposed pursuant to section 44-1302.

10 F. A city or town shall not levy a use tax on the storage, use or
11 consumption of tangible personal property in the city or town by a school
12 district or charter school.

13 G. For the purposes of this section:

14 1. "Cable operator" has the same meaning prescribed in section
15 9-505 **AND INCLUDES A VIDEO SERVICE PROVIDER.**

16 2. "Electrical services" means transmitting or distributing
17 electricity, electric lights, current or power over lines, wires or
18 cables.

19 3. "Telecommunication services" means transmitting or relaying
20 sound, visual image, data, information, images or material over lines,
21 wires or cables by radio signal, light beam, telephone, telegraph or other
22 electromagnetic means.

23 4. "Utility pole" means any wooden, metal or other pole used for
24 utility purposes and the pole's appurtenances that are attached or
25 authorized for attachment by the person controlling the pole.

26 Sec. 25. Section 44-1273, Arizona Revised Statutes, is amended to
27 read:

28 **44-1273. Limited exemptions**

29 A. The following sellers are not required to register and, except
30 for section 44-1278, subsection B and section 44-1282, are exempt from
31 this article:

32 1. A person acting within the scope of a license issued under
33 title 20.

34 2. A person who is either a:

35 (a) Charitable organization as defined in section 44-6551, this
36 state or any county or municipality of this state or its agencies.

37 (b) Political party, candidate for federal, state or local office
38 or campaign committee required to file financial information with federal,
39 state or local election agencies.

40 3. A person making telephone solicitations without the intent to
41 complete and who does not complete the sales presentation during the
42 telephone solicitation but completes the sales presentation at a later
43 face-to-face meeting between the solicitor and the consumer provided that
44 the later face-to-face meeting is not for the purpose of collecting the
45 payment or delivering any item purchased.

1 4. A person who after making a telephone contact with a consumer
2 sends the consumer descriptive literature and does not require payment
3 before the consumer's review of the descriptive literature and the person
4 is not conducting a solicitation involving any of the following:

5 (a) The sale of an investment or an opportunity for an investment
6 that is not registered with any state or federal authority.

7 (b) A prize promotion or premium.

8 (c) A recovery service.

9 (d) A business opportunity or merchandise related to a business
10 opportunity.

11 5. A person or solicitor for a person who operates a retail
12 business establishment under the same name as the name used in the
13 solicitation of sales by telephone, if on a continuing basis all of the
14 following apply:

15 (a) Merchandise is displayed and offered for sale or services are
16 offered for sale and provided at the person's business establishment.

17 (b) At least fifty ~~per cent~~ PERCENT of the person's business
18 involves the buyer obtaining the merchandise at the person's business
19 establishment.

20 (c) The person holds a transaction privilege tax license pursuant
21 to title 42, chapter 5.

22 6. A person or solicitor for a person soliciting another business
23 if all of the following apply:

24 (a) At least fifty ~~per cent~~ PERCENT of the person's dollar volume
25 consists of repeat sales to existing businesses.

26 (b) The person does not conduct a prize promotion that requires or
27 implies that to win a consumer must pay money or purchase merchandise.

28 (c) Neither the person nor any of the person's principals has
29 within twenty years been convicted in any state of a felony or crime of
30 moral turpitude, breach of trust, fraud, theft, dishonesty or violation of
31 telephone solicitation laws, been subject to a final judgment in a civil
32 action involving fraud, deceit or misrepresentation or been subject to an
33 administrative order involving fraud, deceit, misrepresentation or any
34 violation of telephone solicitations laws of any agency of this state,
35 another state, the federal government, a territory of the United States or
36 another country.

37 (d) The person is not selling a business opportunity or merchandise
38 related to a business opportunity.

39 7. A person or solicitor on behalf of a person who solicits sales
40 by periodically publishing and delivering a catalog to consumers if all of
41 the following apply:

42 (a) The catalog contains a written description or illustration of
43 each item offered for sale and the price of each item offered for sale.

44 (b) The catalog includes the business address or home office
45 address of the person.

1 (c) The catalog includes at least twenty-four pages of written
2 material and illustrations.

3 (d) The catalog is distributed in more than one state and has an
4 annual circulation by mail of at least two hundred fifty thousand.

5 B. The following sellers shall file a limited registration
6 statement pursuant to section 44-1272.01 and, except for sections 44-1278
7 and 44-1282, are exempt from this article:

8 1. A person acting within the scope of a license issued under title
9 6 or 32 or by the corporation commission pursuant to this title, except
10 persons licensed under title 6, chapter 13.

11 2. If soliciting within the scope of the license, any licensed
12 securities, commodities or investments broker or dealer or investment
13 advisor or any licensed associated person of a securities, commodities or
14 investments broker or dealer or investment advisor.

15 3. An issuer or a subsidiary of an issuer that has a class of
16 securities that is subject to section 12 of the securities exchange act of
17 1934 (15 United States Code sections 78a through 78mm) and that is either
18 registered or exempt from registration under paragraph (A), (B), (C), (E),
19 (F), (G) or (H) or subsection (g)(2) of section 12 of the act. A
20 subsidiary of an issuer that qualifies for exemption under this paragraph
21 is not exempt unless at least sixty ~~per cent~~ PERCENT of the voting power
22 of the subsidiary's shares is owned by the qualifying issuer or issuers.

23 4. A person certificated or regulated by the corporation commission
24 pursuant to title 40, chapter 2 or a subsidiary of that person or a
25 federal communications commission licensed cellular telephone company or
26 radio telecommunication services provider.

27 5. A person making telephone solicitations for a newspaper of
28 general circulation, a magazine or a licensed ~~or franchised~~ cable
29 television system OR VIDEO SERVICE PROVIDER.

30 6. An issuer or subsidiary of an issuer that is subject to
31 registration under chapter 12, article 6 or 7 of this title or that is
32 exempt from registration under section 44-1843, subsection A, paragraph 1,
33 2, 3, 4, 5, 7 or 9.

34 7. A person making telephone solicitations for the sale or purchase
35 of books, recordings, videocassettes and similar goods through a
36 membership group or club regulated by the federal trade commission or
37 through a contractual plan or arrangement such as a continuity plan,
38 subscription arrangement, series arrangement or single purchase under
39 which the seller ships goods to a consumer who has consented in advance to
40 receive those goods and the recipient is given the opportunity to review
41 goods for at least seven days and to receive a full refund for return of
42 undamaged goods.

43 8. A person or solicitor for a person when soliciting previous
44 customers, if all of the following apply:

1 (a) The person is not offering to sell or selling a security that
2 is not registered with any state or federal authority.

3 (b) The person makes the solicitation under the same name as the
4 name used to sell merchandise to the customer previously.

5 (c) The person does not operate a recovery service.

6 (d) The person does not conduct a prize promotion that requires a
7 consumer to, or implies that to win a consumer must, pay money or purchase
8 merchandise.

9 (e) The person has not, or any of its principals have not, within
10 twenty years been convicted in any state of a felony or a crime of moral
11 turpitude, breach of trust, fraud, theft, dishonesty or a violation of
12 telephone solicitation laws, been subject to a final judgment in a civil
13 action involving fraud, deceit or misrepresentation or been subject to an
14 administrative order involving fraud, deceit, misrepresentation or any
15 violation of telephone solicitation laws of any agency of this state,
16 another state, the federal government, a territory of the United States or
17 another country.

18 9. A person making telephone solicitations exclusively for the
19 purpose of the sale of telephone answering services to be provided by that
20 person or that person's employer.

21 10. Any bank holding company, bank, financial institution, trust
22 company, savings and loan association, credit union, mortgage banker or
23 broker, consumer lender or insurer that is licensed or supervised by an
24 official or agency of this state, any other state or the United States,
25 including any parent, subsidiary or affiliate of these institutions.

26 11. A person providing telemarketing sales service continuously for
27 at least five years under the same ownership and control that derives
28 seventy-five ~~per cent~~ PERCENT of its gross telemarketing sales revenues
29 from contracts with persons exempted by this section. A seller using an
30 exempt telemarketing sales service is not exempt unless otherwise
31 qualifying for an exemption under this section.

32 C. On request by the secretary of state, the director of the
33 department of insurance shall provide a current list in a mutually
34 acceptable electronic format to the secretary of state of the requested
35 licensees described in subsection A, paragraph 1 of this section that
36 includes all of the following information:

37 1. The true legal name of the seller.

38 2. All of the names under which the seller is doing business or
39 intends to do business.

40 3. The complete street address of the physical location of the
41 principal place of business of the seller and the telephone number for the
42 location.

43 4. The name and address of the seller's agent who is authorized to
44 receive service of process in this state.

1 D. In any civil proceeding alleging a violation of this article,
2 the burden of proving an exemption or an exception from a definition is on
3 the person claiming the exemption or exception. In any criminal
4 proceeding in which a violation of this article is alleged, the burden of
5 producing evidence to support a defense based on an exemption or an
6 exception from a definition is on the person claiming the exemption or
7 exception.

8 E. Any person or solicitor exempted in part from this article by
9 this section shall not make or submit a charge to a consumer's credit card
10 account or a consumer's checking, savings, share or similar account unless
11 any of the following applies:

12 1. The person provides that the consumer may receive a full refund
13 for the return of undamaged and unused goods or a cancellation of services
14 by providing notice to the person within seven days after the date that
15 the consumer receives the merchandise and the person processes:

16 (a) A full refund within thirty days after the date that the person
17 receives the returned merchandise from the consumer.

18 (b) A full refund within thirty days after the purchaser of
19 services cancels an order for the services or a pro rata refund for any
20 services not yet performed for the consumer.

21 2. The person provides the consumer with a signed copy of a written
22 contract that includes the person's name, address and business telephone
23 number and that fully describes the merchandise offered by the person, the
24 total price to be charged by the person and any terms or conditions
25 affecting the sale.

26 3. The person is either a:

27 (a) Charitable organization as defined in section 44-6551, this
28 state or any county or municipality of this state or its agencies.

29 (b) Political party, candidate for federal, state or local office
30 or campaign committee required to file financial information with federal,
31 state or local election agencies.

32 Sec. 26. Section 48-620, Arizona Revised Statutes, is amended to
33 read:

34 48-620. Improvement districts for underground utility and
35 cable television facilities in public rights-of-way
36 and easements; procedures; costs; definitions

37 A. Subject to the limitations contained in this section, the powers
38 and duties of the governing body of a municipality for establishing
39 underground utility facilities are as provided in this article for other
40 types of improvement districts.

41 B. Notwithstanding section 48-507, after the governing body passes
42 a resolution or notice declaring its intention to order an improvement
43 district for underground utility facilities, the governing body shall hold
44 a hearing at least thirty days after the completion of the posting and
45 publication of the notice of intention pursuant to section 48-506. At the

1 hearing, the governing body shall consider the issue of ordering an
2 election on the formation of the improvement district and shall receive
3 public comment on the proposed district. Section 48-507, regarding
4 written protests of the proposed improvement, does not apply to a district
5 formed pursuant to this section. The governing body may only order the
6 election on the issue of formation of the district if the owners of real
7 property in the district have signed and submitted petitions to the clerk
8 of the governing body in support of the formation of the district. The
9 petitions shall comply with the following:

10 1. Clearly state that they are petitions in support of the
11 formation of an underground utility improvement district and shall
12 specifically describe in words or by use of a map the location of the
13 proposed district's boundaries. The petitions shall require the signer's
14 signature, name and address or description of the property that is owned
15 in the district in a manner sufficient to determine ownership through the
16 use of public records.

17 2. Be signed by owners of a majority of the real property within
18 the boundaries of the proposed district as measured by square footage or
19 acreage owned. Signatures ~~shall~~ ARE not ~~be~~ required to be notarized and
20 for property with more than one owner, the signature of one owner is
21 binding on the remaining owners of the property. On submittal to the
22 clerk of the governing body, the petitions are a public record. Ownership
23 of property ~~shall be~~ IS as of the date of the hearing and ~~shall be~~ IS
24 determined by records of the county assessor or other public records
25 regarding property ownership. For purposes of this paragraph, "owner"
26 means a person, association, corporation or other entity without regard to
27 residency.

28 C. If the governing body finds that sufficient signatures are
29 submitted pursuant to subsection B of this section, the governing body may
30 proceed with a simplified ballot card election pursuant to subsection G of
31 this section. If there are not sufficient signatures, the governing body
32 shall not proceed with the formation of the district. If no registered
33 voters reside within the area of the proposed district, an election is not
34 required and the governing body may declare the formation of the district.

35 D. The requirement pursuant to section 48-577 that plans and
36 specifications be filed prior to adoption of the resolution of intention
37 may be satisfied by a general plan showing at least the general location
38 and type of facilities to be constructed. Actual plans and specifications
39 shall be filed following the adoption of the resolution ordering the
40 election regarding the improvement but ~~prior to~~ BEFORE the election and
41 the recording of the assessment and warrant. A person interested and
42 objecting to an improvement or to the extent of the assessment district
43 for a district established pursuant to this section may file a written
44 protest with the city or town clerk within thirty days after completion or
45 posting of the notice, or within thirty days after the date of the last

1 publication of the notice if that date is after the completion of the
2 posting.

3 E. The requirement pursuant to section 48-584 for notice of the
4 award of contract may be satisfied by the inclusion in the resolution of
5 intention of the name of the coordinating utility. The ~~fifteen day~~
6 FIFTEEN-DAY period for filing notice of objections under section 48-584,
7 subsection E shall begin ~~upon~~ ON completion of publication and posting of
8 the notice of proposed improvement stating the name of the coordinating
9 utility.

10 F. The governing body shall determine the boundaries of the
11 district and designate the transmission facilities and, if applicable, any
12 independent parallel facilities, to be placed underground and shall obtain
13 from the coordinating utility an accurate statement of the costs of the
14 project, including an estimate of the average cost in assessments on an
15 average single family residence in the district. The amount shall be
16 included in the engineer's estimate required by section 48-577. The costs
17 shall include:

18 1. The amount by which the cost of placing facilities underground
19 would exceed the cost of placing comparable facilities overhead.

20 2. The reconstruction cost and net depreciation costs of any
21 existing facilities to be removed.

22 3. The actual costs of removing such existing facilities, less the
23 salvage value of the facilities removed.

24 4. The charge to finance the costs prescribed in this subsection
25 over a stated period of not to exceed fifteen years.

26 5. The tax reimbursement amount.

27 G. On receipt of an accurate estimate of the costs of the project,
28 the governing body shall call a simplified ballot card election in the
29 area affected by the proposed district. The simplified ballot card shall
30 contain the words for a district formation election "district, yes" and
31 "district, no" and for an assessment election "assessment, yes" and
32 "assessment, no". A single simplified ballot card may be used for both
33 the question of the formation of the district and the question of the
34 assessment. The election may be conducted in a simplified format and
35 administered by the governing body. The governing body shall mail to all
36 registered voters and property owners within the proposed district
37 simplified ballot cards with return postage prepaid. The simplified
38 ballot card shall clearly state that to be valid a voted ballot card shall
39 be returned to the governing body within thirty days after the governing
40 body mails the ballot card and a ballot card that is not timely returned
41 shall not be counted. A person who is qualified to vote in a municipal
42 election for that municipality or a property owner who owns land within
43 the proposed improvement district ~~are~~ IS qualified to vote in an election
44 for a municipal improvement district formed pursuant to this section,
45 except that only residents of or property owners in the area that is

1 within the proposed district may vote. If a majority of the persons
 2 voting with the simplified ballot card approves the formation of the
 3 district and if a majority of the persons voting with the simplified
 4 ballot card approves the assessment, the governing body may form the
 5 district and make the assessment. If more than one governing body is
 6 affected by a proposed district, each governing body may form its own
 7 district for the portion of the work within its jurisdiction. Assessments
 8 for districts that are formed for a portion of the same project shall be
 9 distributed between districts in proportion to the benefits to be
 10 received. When the governing body acquires jurisdiction to order the
 11 work, it shall not call for construction bids but may enter into a
 12 contract or contracts with the utility, utilities or licensed cable
 13 television system whose facilities are to be placed underground. Prior to
 14 entering into a contract or contracts the coordinating utility shall
 15 submit a final report to the municipality. The amount stated in the final
 16 report may be based on detailed engineering studies. If the amount stated
 17 in the final report exceeds the amount stated in the preliminary report
 18 the governing body may either:

- 19 1. Terminate the project.
- 20 2. Call a new election on the improvement.

21 H. The contract shall provide for payment to the utility or
 22 licensed cable television system over a term of not to exceed fifteen
 23 years of the amount set forth in the final report, shall specify those
 24 facilities to be owned by the municipality and those to be owned by the
 25 utility, utilities or licensed cable television system and shall contain
 26 such provisions for the prepayment of any assessment at the option of any
 27 property owner, and such other terms, covenants and conditions as the
 28 governing body and the utility, utilities or licensed cable television
 29 system determine. The licensed cable television system shall not be
 30 entitled to reimbursement except where the cable television system's
 31 parallel facilities are installed to replace existing cable television
 32 facilities other than independent parallel facilities not included by the
 33 governing body in the work. The amount payable on the contract or
 34 contracts ~~shall be~~ IS payable solely from amounts collected on the
 35 assessment levied in the district. ~~No~~ A payment or performance bond ~~shall~~
 36 ~~be~~ IS NOT required of a utility or licensed cable television system
 37 entering into a contract with the governing body.

38 I. The municipality may retain an independent engineering
 39 consultant to review all reports, estimates and costs provided by the
 40 coordinating utility.

41 J. The coordinating utility shall advance or reimburse a governing
 42 body for the costs of forming the district and the cost of printing,
 43 advertising and posting incurred or to be incurred by a governing body and
 44 shall bear its own expenses for engineering and design, and preparing the
 45 reports, plans and specifications. ~~Upon~~ ON completion of the work, the

1 coordinating utility shall reimburse a governing body for its reasonable
2 expenses incurred with respect to the district. Unless otherwise provided
3 for in a manner acceptable to the coordinating utility, the amounts
4 advanced or reimbursed shall be included in the contract and in the amount
5 assessed.

6 K. This section does not amend or modify any existing line
7 extension policies of any utility involved. The costs to be reimbursed
8 under the contract shall be reduced to the extent of amounts paid or to be
9 paid by landowners or from other sources directly to the utility or cable
10 television system for the installation of the facilities.

11 L. The assessment and warrant may be recorded at any time following
12 approval of the project at an election. The hearing on the assessment may
13 be held at any time not less than twenty days from the date of recording
14 of the assessment and warrant. An additional hearing following notice
15 from the superintendent of streets to the governing body of completion of
16 the work shall be requested only if any member of the governing body or
17 any owner of or any person claiming an interest in any lot ~~which~~ THAT
18 received an assessment, within one year of the date of the notice of
19 completion, files a written notice with the clerk stating that the work
20 has not been performed substantially in accordance with the resolution of
21 intention, the plans and specifications and estimate. The notice shall
22 state in particular the failure to perform and may also state, if
23 applicable, any requested reduction in the assessment of any one or more
24 parcels due solely to the failure of such performance. The notice shall
25 state the name and address of the person filing the notice and shall
26 describe such person's interest in land subject to assessment. The
27 governing body may enforce the contract and may recess the hearing to
28 permit the utility or licensed cable television system to complete the
29 work. If the work cannot be completed, the assessment may be adjusted to
30 take the failure to complete into consideration. The amount due under the
31 agreement with the utility or licensed cable television system shall be
32 adjusted accordingly. Repayment under the contract shall be conditioned
33 on completion of the work and approval of the assessment as provided by
34 law. Unless an objection has been filed, repayment shall begin within
35 nine months of the notice of completion.

36 M. An improvement district formed pursuant to this section shall
37 not issue bonds, and the assessment for district purposes against the
38 property within the district shall not exceed the amount specified in the
39 engineer's estimate. Notwithstanding any other statute, the assessment
40 for an underground electrical power line shall not be assessed against the
41 owners of the frontage of the right-of-way of the underground power line
42 but shall be assessed against all property owners benefiting from the
43 burial of the power line.

1 N. The governing body shall provide for the levy and collection of
2 assessments on the real property in the district in the manner provided
3 for in this article. However, the assessment may be paid in installments
4 necessary to pay amounts due under the contract and to reimburse the
5 municipality for expenses incurred as provided in the assessment.

6 O. A district formed under this section shall not engage in any
7 activity other than contracting for or establishing underground
8 transmission facilities together, where applicable, with parallel
9 facilities.

10 P. The governing body by resolution may summarily determine that it
11 will participate in the costs of the improvement. If the municipality is
12 willing to assume the total outstanding assessment for the underground
13 utility facilities, the governing body may summarily dissolve the district
14 by resolution after payment of all liabilities including all amounts due
15 under the contract.

16 Q. The formation of an improvement district for underground utility
17 facilities under this section does not prevent the establishment of other
18 improvement districts which may include all or part of the same property
19 for any purposes authorized by law.

20 R. If a petition for the formation of an improvement district for
21 underground utilities is presented to the governing body, and the petition
22 purports to be signed by all of the real property owners in the proposed
23 district exclusive of mortgagees and other lienholders, the governing
24 body, after verifying such ownership and making a finding of such fact,
25 may adopt a resolution of intention to order the proposed improvement
26 pursuant to section 48-576 and has immediate jurisdiction to adopt the
27 resolution ordering the improvement pursuant to section 48-581, without
28 the necessity of publication and posting of the resolution of intention
29 provided for in section 48-578.

30 S. If the governing body determines that a parcel of property is a
31 single family residence and that payment of the assessment would cause a
32 financial hardship on the owners which would be likely to cause a
33 delinquency in payment of the assessment, the assessment for an
34 improvement made under this section shall provide for an extension in the
35 time to pay principal and interest on the assessment against that parcel
36 for a period of time not to exceed ten years. If the governing body
37 determines that the grounds for extension no longer exist, then the
38 extension will be terminated and all payments ~~which~~ THAT would have been
39 due but for the extension shall become due. The assessment shall provide
40 for adjustments in the assessments against the remaining parcels to
41 provide for timely payment under the agreement.

42 T. Notice of the passage of a resolution of intention for an
43 improvement under this section shall be given to the corporation
44 commission and, where the improvement involves a utility regulated
45 thereby, the rural electrification administration.

1 U. In this section, unless the context otherwise requires:

2 1. "Coordinating utility" means the utility whose proposed or
3 existing transmission facilities are to be placed underground. The
4 coordinating utility is responsible for assembling into one report cost
5 estimates and other data provided by each utility or licensed cable
6 television system whose facilities are to be placed underground.

7 2. "Cost" means all costs of design and construction of facilities.

8 3. "Facilities" means any works or improvements used or useful in
9 providing electric, communications, ~~or~~ licensed cable television service
10 ~~OR VIDEO SERVICE~~, including ~~but not limited to~~ poles, supports, tunnels,
11 manholes, vaults, conduits, pipes, wires, conductors, guys, studs,
12 platforms, crossarms, braces, transformers, insulators, cutouts, switches,
13 capacitors, meters, communication circuits, appliances, attachments and
14 appurtenances but excluding any works for transmission by microwave or
15 radio. Facilities shall include only transmission facilities and parallel
16 facilities.

17 4. "Governing body" means the council of a city or town or the
18 board of supervisors of a county.

19 5. "Independent parallel facilities" means existing parallel
20 facilities ~~which~~ ~~THAT~~ do not rely for their support on poles or other
21 structures to be removed as part of the work. If the utility or licensed
22 cable television system elects to remove the independent parallel
23 facilities but the removal and underground replacement thereof was not
24 included by the governing body in the work, the reconstruction and removal
25 costs of such independent parallel facilities shall not be included in a
26 contract or be assessed.

27 6. "Parallel facilities" means facilities that run or are permitted
28 to run in the easement in which the transmission facilities are to be
29 placed underground and that may be included underground with the
30 transmission facilities, and facilities appurtenant thereto. Any parallel
31 facilities shall have a right to be included underground and have access
32 to a trench on such reasonable terms and conditions as the coordinating
33 utility and the owners of the parallel facility may determine provided
34 they do not interfere with the installation or operation of the
35 transmission facilities.

36 7. "Private parallel facilities" means parallel facilities other
37 than those owned or operated by a public utility or licensed cable
38 television system. Private parallel facilities have the rights of
39 parallel facilities except that the costs thereof shall not be included in
40 a contract or be assessed.

41 8. "Tax reimbursement" means an annual charge for reimbursement for
42 property taxes, or voluntary contributions in lieu of property taxes as
43 provided in chapter 1, article 8 of this title, by applying the tax rates
44 in effect on the date of adoption of the resolution of intention to the
45 amount by which the estimated average taxable value of underground

1 facilities, excluding the value of trenches, backfill and compaction, on
2 completion exceeds the estimated average taxable value of comparable
3 overhead facilities. In this paragraph, "estimated average taxable value"
4 means the average of the estimated taxable value for each year of
5 reimbursement. The value of the trenches, backfill and compaction of the
6 underground facilities shall be attributed to and shall inure to the
7 benefit of the owners of property within the district and shall be owned
8 by the city. Reimbursement shall not be for a period longer than fifteen
9 years.

10 9. "Transmission facilities" means facilities ~~which~~ THAT are, or
11 are appurtenant to, electric transmission lines of more than twenty-five
12 kilovolts but not more than two hundred thirty kilovolts in size.

13 Sec. 27. Section 48-5107, Arizona Revised Statutes, is amended to
14 read:

15 48-5107. Utility relocation reimbursement: definition

16 A. All costs for the relocation, and reasonable ongoing costs
17 related to the relocation, of utility facilities incurred after July 1,
18 2003 as a direct result of the construction and operation of a light rail
19 project shall be reimbursed by the light rail project to the utility. The
20 board shall make the payments from transportation excise tax revenues
21 allocated pursuant to section 48-5103, subsection A, paragraph 3,
22 subdivision (a) within ninety days after presentation of a statement of
23 verified expenses. The statement of verified expenses shall not include
24 profit but may include a reasonable allocation of general overhead. The
25 verified expenses may be reviewed and audited by the light rail operator,
26 but the audit must be concluded within ninety days and shall be conducted
27 pursuant to standard industry accounting principles.

28 B. If the relocated utility has existing land rights, the light
29 rail operator shall relocate the utility with equal land rights. If the
30 relocated utility is operating in the right-of-way under a permit, the
31 light rail operator shall relocate the utility according to the utility's
32 existing rights under the permit within the right-of-way.

33 C. The light rail operator shall be fully responsible for acts,
34 negligence or omissions of all of its employees on the project that result
35 in damage to utility facilities.

36 D. For the purposes of this section, "utility" means any public
37 service corporation, agricultural improvement district, licensed cable
38 television system, LICENSED VIDEO SERVICE NETWORK, telephone line or
39 telegraph line corporation or person engaged in the generation,
40 transmission or delivery of electricity, natural gas, telephone, cable
41 television, VIDEO, telegraph or water service, including this state or any
42 political subdivision or agency of this state.

1 Sec. 28. Section 48-5315, Arizona Revised Statutes, is amended to
2 read:

3 48-5315. Utility relocation reimbursement; definition

4 A. If county transportation excise tax monies collected pursuant to
5 section 42-6106 are used to construct a light rail system under the
6 regional transportation plan, all costs for the relocation, and reasonable
7 ongoing costs related to the relocation, of utility facilities incurred as
8 a direct result of the construction and operation of the light rail system
9 shall be reimbursed by the light rail project to the utility. The board
10 shall make the payments from transportation excise tax revenues within
11 ninety days after presentation of a statement of verified expenses. The
12 statement of verified expenses shall not include profit but may include a
13 reasonable allocation of general overhead. The verified expenses may be
14 reviewed and audited by the light rail operator. The audit must be
15 concluded within ninety days and shall be conducted pursuant to standard
16 industry accounting principles.

17 B. If the relocated utility has existing land rights, the light
18 rail operator shall relocate the utility with equal land rights. If the
19 relocated utility is operating in the right-of-way under a permit, the
20 light rail operator shall relocate the utility according to the utility's
21 existing rights under the permit within the right-of-way.

22 C. The light rail operator shall be fully responsible for acts,
23 negligence or omissions of all of its employees on the project that result
24 in damage to utility facilities.

25 D. For the purposes of this section, "utility" means any public
26 service corporation, licensed cable television system, LICENSED VIDEO
27 SERVICE NETWORK, telephone line or telegraph line corporation or person
28 engaged in the generation, transmission or delivery of electricity,
29 natural gas, telephone, cable television, VIDEO, telegraph or water
30 service, including this state or any political subdivision or agency of
31 this state.

32 Sec. 29. Conditional enactment

33 Section 42-6004, Arizona Revised Statutes, as amended by Laws 2018,
34 chapter 17, section 1, chapter 249, section 6, chapter 263, section 3,
35 chapter 341, section 2 and this act, becomes effective on the date
36 prescribed by Laws 2018, chapter 263, section 5 but only on the occurrence
37 of the condition prescribed by Laws 2018, chapter 263, section 5.

APPROVED BY THE GOVERNOR MAY 1, 2019.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MAY 1, 2019.



AGENDA ITEM REVIEW FORM

Special City Council Meeting

5.D.

Meeting Date: 06/25/2019

Department Head: Kay Macuil, City Attorney, Attorney's Office

Submitted By: Kay Macuil, City Attorney, Attorney's Office

Action Requested: Motion

ITEM:

Discussion and possible action on any and all matters regarding employee benefits contracts which are not administered by the San Luis Employee Benefits Trust. **(Maria Muñoz, Human Resources Technician)**

SUMMARY:

Background

At the budget meeting on April 26, 2019, Benefits Broker and Consultant Susan Posada presented costs and other information for City Council's consideration regarding renewing the employee benefits. (A copy of the PowerPoint provided at that meeting is attached).

The San Luis Employee Benefits Trust does not administer all the employee benefits. The city contracts directly for some of the employee benefits. Those contracts are the vision care plan, short-term disability, long-term disability (for public safety employees only), basic life insurance including accidental death and dismemberment, and a medical plan through Transwestern Insurance. The Transwestern Insurance is a small contract of \$96,50 and was approved by the City Manager under his purchasing authority.

Policies that are changing

Changes Ms. Posada negotiated this year include:

1. A 4-year lock on the vision care rates (Ms. Posada informs us that without a change in rate, the provider does not require a signature); and
2. Expansion of short-term disability benefits, which will allow employees who are eligible for short-term disability to take sick leave while on disability up to 100% of their income.
3. The accidental death and dismemberment coverage rate changed from a premium of 40¢ per \$1,000 of benefits to 50¢ per \$1,000.00 of benefit.

Since City Council had no objection to these changes at the budget meeting in April, staff included these changes in the summary of benefits at open enrollment in May. Other contracts remain the same.

Staff recommends approval of these changes.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE THE FOUR-YEAR LOCK ON RATES FOR THE VISION BENEFIT, THE AMENDMENT TO THE SHORT-TERM DISABILITY AND THE RATE CHANGE FOR ACCIDENTAL DEATH AND DISMEMBERMENT AS PRESENTED.

N/A

Fiscal Impact

IS THERE FISCAL IMPACT ASSOCIATED WITH THIS ITEM: Yes
CITY/STATE/FEDERAL FUNDS: City
TOTAL: 148196.83
BUDGETED AMOUNT: ?
AVAILABLE AMOUNT TO TRANSFER: N/A
ACCT NAME & GL#/REMAINING BALANCE BEFORE PURCHASE: ?
FISCAL IMPACT STATEMENT (IF THIS IS A BUDGET TRANSFER, YOU MUST ATTACH THE BUDGET ADJUSTMENT FORM):

The annual premium for the vision plan is \$45,747.48

The annual premium is estimated to be \$21,334.73

The annual premium for the short-term disability is with the amendment is \$81,114.62 (this is a 37.12% change and \$21,956.80 increase)

Attachments

2019 Budget Mtg Benefits Presentation

Renewal letter 2019

Short-Term Disability

Accident Death & Dismemberment



CITY OF
San Luis Arizona
Gateway to the Sea of Cortez

Trust Meeting
2019 Renewal Presentation

For July 1, 2018 to June 30, 2019

Presented by Susan Posada



SUSAN POSADA
AGENCY

Trust Expenses Covered by Trust

1. Stop Loss
2. Third Party Administrative Fees
 - a. Network Fees
 - i. Blue Cross Blue Shield of AZ – US network
 - ii. Siarmed – Mexico network both medical and dental
 - b. Broker Fees
 - c. Flu Shots for Mexico members
 - d. ACA Reporting Fees
 - e. Claims Utilization
 - f. Cobra Fees
 - g. HealthiestYou (Teledoc)
 - h. EAP – All Employees
 - i. ACA fees
3. Overall – Medical and Dental design, and cost
4. Trust Fund Balance

Not included in Trust

1. Vision plan
2. Basic and Voluntary life
3. Short- and Long-term disability
4. Transwestern voluntary medical plan
5. EAP for Public Safety
6. FMLA

City of San Luis
Changes to Plan Costs
Plan Year 7/1/2019 to 6/30/2020

Budget Increase						Percentage Increase
	Total All Benefit	Employer Portion	Employee Portion			
City - Increase	\$890.28	\$414.16	\$476.12			0.03%
City - Increase with STD Option 2	\$29,249.87	\$29,249.87	\$0.00			1.03%
Trust - Increase with EAP only	\$6,402.24	\$6,402.24	\$0.00			

Total Trust Budget based on recommendations \$2,650,082.04
See details in the Contribution Comparison Sheet for 2019 to 2020

Plan Changes						
Service Changes	Annual Premium 2015	Annual Premium 2016	Annual Premium 2017	2018	2019	Rates % change
Stop Loss	\$432,036.36	\$429,267.12	\$434,847.36	\$483,023.64	\$437,532.72	-10.46%
Mayo/EBSO Fees						
Medical	\$18.00	\$18.50	\$18.60	\$24.50	\$24.50	0.00%
Dental	\$2.90	\$2.90	\$2.95	\$3.00	\$3.00	0.00%
Claims Utilization/ACA FEE	\$3.00	\$3.25	\$3.50	\$3.00	\$3.00	0.00%
Cobra Optum	\$0.79	\$0.74	\$0.74	Incl	Incl	Incl
Siarmed						
Medical	\$3.00	\$3.00	\$3.00	\$3.00	\$3.00	0.00%
Dental	\$1.25	\$1.25	\$1.25	\$1.25	\$1.25	0.00%
Broker Fees	\$32.00	\$33.50	\$33.50	\$35.00	\$35.00	0.00%
BCBS Network Fees	\$15	\$15.50	\$15.75	\$16.00	\$17.50	9.38%

- Mexico network changed to Siarmed effective 4/1/2016

- Stop Loss fees are subject to change pending the 4/31/2019/2019 claims reports

** BCBC negotiated the rate for 2 years \$17.50 PEPM

***Siarmed had agreed to a 3 year agreement (to 6/30/2020) with no price changes in the admin fees and provider fees

City of San Luis

Medical and Dental Enrollment Changes

Medical Enrollment				Dental Enrollment		
	February 1, 2018	February 1, 2019	Percentage Change	February 1, 2018	February 1, 2019	Percentage Change
US/Mexico						
Employees Only	123	123	0.00%	124	127	2.42%
Employee & Spouse	7	5	-28.57%	7	5	-28.57%
Employee and Children	42	42	0.00%	42	28	-33.33%
Family	20	22	10.00%	20	23	15.00%
Mexico Only						
Employees Only	1	1	0.00%	4	0	-100.00%
Employee & Spouse	4	5	25.00%	4	9	125.00%
Employee and Children	10	10	0.00%	10	16	60.00%
Family	24	24	0.00%	24	29	20.83%
Total	222	232	4.50%	223	223	0.00%
Average Members	569	518	-8.96%	538	535	-0.56%

2012-2013 EE's 154 total dep. 570

CITY OF SAN LUIS
STOP LOSS AND ADMINISTRATION RENEWAL EFFECTIVE JULY 1, 2019

DESCRIPTION										
	2018-20199 Current Symetra	2019-2020 Renewal Symetra	2018-2019 Initial Quote Option 1 Symetra	2018-2019 Initial Quote Option 2 Symetra	2018-2019 Initial Quote Option 3 Int'l/Sirius America	2018-2019 Initial Quote Option 4 Int'l/Sirius America	2018-2019 Initial Quote Option 5 Int'l/Sirius America			
STOP LOSS POLICY TERMS		\$50,000 Stop Loss	\$50,000 Stop Loss	\$75,000 Stop Loss	\$100,000 Stop Loss	\$50,000 Stop Loss	\$75,000 Stop Loss	\$100,000 Stop Loss		
Specific Lifetime Maximum		Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited		Unlimited
Specific Annual Reimbursement		Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited		Unlimited
Specific Deductible		\$ 50,000	\$ 50,000	\$ 75,000	\$ 100,000	\$ 50,000	\$ 75,000	\$ 100,000		\$ 100,000
Specific Contract Basis		Paid	Paid	Paid	Paid	Paid	Paid	Paid		24/12
Specific Coverage		Medical	Medical	Medical	Medical	Medical	Medical	Medical		Medical
Specific Run-In Limits		N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Lasered Individuals		None	None	None	None	None	None	None		None
Aggregate Maximum		\$ 1,000,000	\$ 1,000,000	\$ 1,000,000	\$ 1,000,000	\$ 1,000,000	\$ 1,000,000	\$ 1,000,000		\$ 1,000,000
Aggregate Coverage		Medical & RX Card	Medical & RX Card	Medical & RX Card	Medical & RX Card	Medical & RX Card	Medical & RX Card	Medical & RX Card		Medical & RX Card
Aggregate Contract Basis		Paid	Paid	Paid	Paid	24/112	24/112	24/112		24/112
Aggregate Run-In Limits		N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Corridor		25%	25%	25%	25%	25%	25%	25%		25%
STOP LOSS PREMIUM										
Specific Premium										
Employee Rate	124	\$ 88.26	\$ 88.26	\$ 68.32	\$ 53.84	124 \$ 91.82	\$ 69.27	\$ 53.46		\$ 53.46
Employee + Spouse Rate	10	\$ 266.18	\$ 266.18	\$ 210.17	\$ 169.53	10 \$ 201.07	\$ 151.70	\$ 117.07		\$ 117.07
Employee + Child(ren) Rate	52	\$ 266.18	\$ 266.18	\$ 210.17	\$ 169.53	52 \$ 174.44	\$ 131.61	\$ 101.57		\$ 101.57
Employee + Spouse + Children Rate	46	\$ 266.18	\$ 266.18	\$ 210.17	\$ 169.53	46 \$ 286.46	\$ 216.12	\$ 166.79		\$ 166.79
Projected Total Monthly Specific Premium	232	\$ 39,691.68	\$ 39,691.68	\$ 31,170.04	\$ 24,985.40	232 \$ 35,644.42	\$ 26,891.72	\$ 20,753.72		\$ 20,753.72
Aggregate Rate PEPM	232	\$ 3.62	\$ 3.62	\$ 3.59	\$ 3.65	232 \$ 3.52	\$ 3.75	\$ 3.89		\$ 3.89
Projected Monthly Aggregate Premium		\$ 861.84	\$ 839.84	\$ 832.88	\$ 846.80	\$ 816.64	\$ 870.00	\$ 902.48		\$ 902.48
TOTAL PROJECTED PREMIUM										
Monthly		\$ 40,553.52	\$ 40,531.52	\$ 32,002.92	\$ 25,832.20	\$ 36,461.06	\$ 27,761.72	\$ 21,656.20		\$ 21,656.20
Annual		\$ 486,642.24	\$ 486,378.24	\$ 384,035.04	\$ 309,986.40	\$ 437,532.72	\$ 333,140.64	\$ 259,874.40		\$ 259,874.40
Percentage of increase over current			-0.05%	-21.08%	-36.30%	-10.09%	-31.54%	-46.60%		
MAXIMUM CLAIM FUNDING FACTORS										
Employee	124	\$ 328.71	\$ 318.84	\$ 343.07	\$ 358.69	124 \$ 382.26	\$ 405.94	\$ 422.48		\$ 422.48
Employee + Spouse	10	\$ 816.84	\$ 792.31	\$ 852.52	\$ 891.35	10 \$ 827.15	\$ 889.00	\$ 925.21		\$ 925.21
Employee + Children	52	\$ 816.84	\$ 794.31	\$ 852.52	\$ 892.35	52 \$ 726.29	\$ 771.28	\$ 802.70		\$ 802.70
Employee + Spouse + Child(ren)	46	\$ 816.84	\$ 794.31	\$ 816.84	\$ 816.84	46 \$ 1,192.65	\$ 1,266.52	\$ 887.62		\$ 887.62
TOTAL PROJECTED MAXIMUM FUNDING	232					232				
Monthly		\$ 128,978.76	\$ 125,301.64	\$ 132,971.56	\$ 137,367.90	\$ 148,300.72	\$ 157,593.04	\$ 142,214.60		\$ 142,214.60
Annual		\$ 1,547,745.12	\$ 1,503,619.68	\$ 1,595,658.72	\$ 1,648,414.80	\$ 1,779,608.64	\$ 1,891,116.48	\$ 1,706,575.20		\$ 1,706,575.20
Percentage of increase over current			-2.85%	3.10%	6.50%	14.98%	22.19%	10.26%		
PROJECTED ADMINISTRATION COSTS										
TPA Claims Administration Fee - Mayo Health	232	\$ 24.50	\$ 24.50	\$ 24.50	\$ 24.50	232 \$ 24.50	\$ 24.50	\$ 24.50		\$ 24.50
Dental Claims Administration US Mayo Health	238	\$ 3.00	\$ 3.00	\$ 3.00	\$ 3.00	232 \$ 3.00	\$ 3.00	\$ 3.00		\$ 3.00
ACA 1095/1094 Reporting	268	\$ 3.00	\$ 3.00	\$ 3.00	\$ 3.00	268 \$ 3.00	\$ 3.00	\$ 3.00		\$ 3.00
PPO Medical Access Fee - BCBS	198	\$ 16.00	\$ 17.50	\$ 17.50	\$ 17.50	198 \$ 17.50	\$ 17.50	\$ 17.50		\$ 17.50
Mexico Siamed/SSA Medical and Dental Claims Admin.	238	\$ 4.25	\$ 4.25	\$ 4.25	\$ 4.25	238 \$ 4.25	\$ 4.25	\$ 4.25		\$ 4.25
Total Monthly Administration		\$ 11,381.50	\$ 11,678.50	\$ 11,678.50	\$ 11,678.50	\$ 11,660.50	\$ 11,660.50	\$ 11,660.50		\$ 11,660.50
Total Annual Administration		\$ 136,578.00	\$ 140,142.00	\$ 140,142.00	\$ 140,142.00	\$ 139,926.00	\$ 139,926.00	\$ 139,926.00		\$ 139,926.00
Patient Centered Research Inst. (Est.)	535	\$ 1,278.65	\$ 131.00	\$ 1,310.75	\$ 1,310.75	535 \$ 1,310.75	\$ 1,310.75	\$ 1,310.75		\$ 1,310.75
Total Annual ACA fees	535	\$ 1,278.65	\$ 131.00	\$ 1,310.75	\$ 1,310.75	535 \$ 1,310.75	\$ 1,310.75	\$ 1,310.75		\$ 1,310.75
Total Annual Administration Fees With Reinsurance & PPCORI		\$ 137,856.65	\$ 140,273.00	\$ 141,452.75	\$ 141,452.75	\$ 141,236.75	\$ 141,236.75	\$ 141,236.75		\$ 141,236.75
Percentage of Increase/Decrease Over Current			1.8%	2.6%	2.6%	2.5%	2.5%	2.5%		2.5%
TOTAL PROJECTED PREMIUM, CLAIMS FUNDING & ADMINISTRATION COSTS										
Monthly		\$ 178,410.17	\$ 180,804.52	\$ 173,455.67	\$ 167,284.95	\$ 177,697.81	\$ 168,998.47	\$ 162,892.95		\$ 162,892.95
Annual		\$ 2,140,922.04	\$ 2,130,270.92	\$ 2,121,146.51	\$ 2,099,853.95	\$ 2,132,373.72	\$ 2,027,981.64	\$ 1,954,715.40		\$ 1,954,715.40
Percentage of Increase Over Current			-0.50%	-0.92%	-1.92%	-0.40%	-5.28%	-8.70%		

- Rates for the Stop Loss and Aggregate are not final until 4/30/2019 BCBS Network fee originally increase to \$17.50 for 1 year - negotiated 2 years for \$17.50

PPCOR fees for 2017 \$2.30 and 2018 \$2.45 for Average number of lives insured

Rates and benefits are illustrative only and represent only a brief summary of the plan highlights. Final rates will be determined from effective date, actual enrollment and/or health conditions. For actual benefits refer to the carrier proposal.

Rates and Benefits represent only a summary of benefits and rates. Refer to plan document, SBCs and Summaries for details.

Stop Loss Change - Risk and Exposure

	2017-2018	2018-2019*	2018-2019*
Large Claims	\$50,000.00	\$50,000.00	\$75,000.00
Number	5	11	11
Total Potential Exposure	\$250,000	\$550,000	\$825,000
Premium	\$486,642	\$437,533	\$333,140
Difference	\$236,642	(\$112,467)	(\$491,860)

* claims are for 8 months

Estimated Fund Balance	
As of 2/28/2019	
Trust Checking	\$1,547,623.26
Trust Savings as of 12/31/2019	\$1,389,093.29
	\$2,936,716.55
Claims Lag	(\$489,030.00)
Incurred but not reported (IBNR)	(\$261,794.46)
Estimated Total	\$2,185,892.09
Expected Liability	\$2,795,256.48
Percentage	78.20%

2019-2020\$ Fund Requirements	
As of 2/28/2019	
Required Funding for 2019 to 2020	\$2,789,098.56
No Increase - Funding level Funding (same as prior year)	\$2,650,02.04
Under Funding	\$139,016.52

EAP and Healthiest You

EAP Preferred						
EAP Visits	EE Total	Visits	Cost PEPM	Monthly Total	Yearly Total	Guarantee
Non-Public Safety Employee	154	3	\$2.17	\$334.18	\$4,010.16	6/30/2022
Non-Public Safety Employee	154	6	\$3.05	\$469.70	\$5,636.40	6/30/2022
All Employees	234	6	\$2.28	\$533.52	\$6,402.24	6/30/2022
All Employees	234	12	\$4.45	\$1,041.30	\$12,495.60	6/30/2022
Public Safety	80	12	\$6.30	\$504.00	\$6,048.00	6/30/2021
* Public Safety 2 and 1/2 years is due to initial contract ending 12/31 and changed to coincide with plan year of 7/1						

Rates are for 7/1/2019

The present contract runs to 7/1/2021

Recommend 6 Visits for all employees with the EAPP Traumatic Agreement wit EAP for all Public Safety

- 24-Hour Access
- Referrals and Follow-up
- Legal and Financial Services
- Orientation and Training
- Communication Materials
- Utilization Reporting

On-site Service Rates	EAP Preferred
CISD (Critical Incident Services)	\$275/\$175
Training, SPV Training	\$275/\$175

Healthiest You TeleDoc				
	Employees	Fixed Cost	Monthly Total	Annual Total
PEPM	234	\$8	\$1,872	\$22,464

PEPM: Premium per Employee per Month

This plan has already been approved by the Trust

ACA Reporting

ACA Reporting		EBSO	Basic
	EE Total		
ACA Reporting Fee	238	\$3.00	\$9.25
Set-up Fee			\$250.00
Total Rate Monthly		\$714.00	\$2,201.50
Total Annual Rates		\$8,568.00	\$26,418.00

City of San Luis Recommended Plan Changes for plan year 2019-2020

	Current 2018-2019	Recommended Renewal 2019-2020
US Medical Plan Recommended Changes		
X-Ray and Lab's		
At Primary Care/Specialist	\$15/\$25 Copay	\$15/\$25 Copay
At Contracted Provider i.e. Sonora Quest and Lab Corp	20% + deductible	\$15 Copay
At a hospital	20% + deductible	20% + deductible
Complex Imaging - Mri, CT Pet Scan etc.		
At Contracted Provider i.e. Sonora Quest and Lab Corp	20% + deductible	\$25 Copay
At a hospital - Complex, MRI, CT and Pet Scan		20% + deductible
Hospitalization		
Pre-Certification	Required	Remove Pre-Cert Requirement
CT Scans, PetScans & MRI's	Required	Remove Pre-Cert Requirement
Special Services such as acupuncture, podiatry & TMJ		Remove Pre-Cert Requirement
No Changes		
Deductible		
In-Network Member	\$750	\$750
In-Network Family	\$1,500	\$1,500
No Changes		
Annual Out of Pocket Maximum		
In-Network Member	\$5,500	\$5,500
In-Network Family	\$11,000	\$11,000
Out of Network - Member	\$20,000	\$20,000
Out-of-Network Family	\$40,000	\$40,000

City of San Luis Recommended Mexico Plan Changes for 2019-2020

Mexico Dental Plan		Recommended
	Current	Renewal
	2018-2019	2019-2020
Mexico Dental Plan (As requested by Siarmed)		
Major Restorative Services Charges to the Trust		
D7472 Removal of Torum Palatinus	\$150	\$250
Maximum Out of Pocket (In Network)	\$150	\$250
D7485 Surgical Reduction of Osseous Tuberosity	\$150	\$250
Orthodontic		
D0340 Cephalometric Film	\$28	\$44
D3050 Panoramic Film	N/A	\$44
D0470 Diagnostic Cast	N/A	\$28
D8030 Limited Orthodontic Treatment of Adolescent Denition	N/A	\$500
D8670 Periodic Orhtodontic Treatment Visit Cast Part of Contract	N/a	\$500
Other Internal Changes		
Rx Copay - Charges to Employee		
RX Copay	N/A	\$3/\$6 Copay
Mexico Medical Plan Change		
Emergency Room - In and out of Network	\$250	\$150

City of San Luis Recommended Plan Changes - Incentive Plan for plan year 2019-2020

Incentive Plan	Recommended Change	
	Current 2018-2019	Renewal 2019-2020
US Medical Plan		
Incentive Program		
Reimbursement for Incentive Program		
Coinsurance Trust pays 80% member 20%	20%	20%
Maximum Out of Pocket (In Network)	\$5,500.00	\$5,500.00
In-Patient - Lodging Reimbursement	None	Up to \$125 per night up to 4 nights
Out-Patient - Lodging Reimbursement	None	Up to \$125 per night up to 4 nights
Maximum Out of Pocket (In Network)	\$5,500.00	\$5,500 Plus lodging reimbursements
Hospitalization for Incentive Program		
Hospitalization and Out-patient	20% + deductible	0% + deductible
	Member pays	Member pays
X-Ray and Lab's		
At Primary Care Provider - Diagnostic, X-ray and Lab	\$15 Copay	\$15 Copay
At Secondary Care Provider - Diagnostic, X-ray and Lab	\$25 Copay	\$25 Copay
At Contracted Provider i.e. Sonora Quest and Lab Corp	20% + deductible	\$15 Copay
At an hospital -	20% + deductible	20% + deductible
Complex Imaging - Mri, CT Pet Scan etc.		
At Contracted Provider i.e. Sonora Quest and Lab Corp	20% + deductible	\$25 Copay
At a hospital - Complex, MRI, CT and Pet Scan	20% + deductible	20% + deductible
Out of Network - Member	\$20,000	\$20,000
Out-of-Network Family	\$40,000	\$40,000

City of San Luis Incentive Program Savings Examples

The City of San Luis has created an Incentive Program for employees to help save money on expensive outpatient procedures and imaging. By taking advantage of the facilities listed in the Incentive Program, members can experience significant savings when compared to going to Yuma Regional Hospital and other local outpatient facilities.

Here are some examples of the savings you could experience by using the Incentive Program Facilities.

Example #1:

Procedure needing to be complete: Knee Replacement

Cost To An Employee For Going To Yuma Regional Hospital	Cost To An Employee For Going To Recommended Facility
Deductible: \$750.00	Deductible: \$750.00
Coinsurance Percentage Employee Is Responsible For: 20%	Coinsurance Percentage Employee Is Responsible For: 0%
Coinsurance Estimated Dollar Amount Employee Is Responsible For Before The Out of Pocket Max Is Met: \$4,750.00	Employee Does Not Pay Any Coinsurance For The Knee Replacement
Total Cost To Employee: \$5,500.00	Total Cost To Employee: \$750.00

Example #2:

Procedure needing to be complete: X-Ray of Ankle

Cost To An Employee For Going To Yuma Regional Hospital	Cost To An Employee For Going To Sonora Quest or Lab Corp
Deductible: \$750.00	Deductible: \$750.00
Coinsurance Percentage Employee Is Responsible For: 20%	Copay Dollar Amount Employee Is Responsible For: \$15.00
Coinsurance Estimated Dollar Amount Employee Is Responsible For Before The Out of Pocket Max Is Met: \$0.00 because deductible has not been met yet	Employee Does Not Pay Any Coinsurance For an X-Ray when going to Sonora Quest or Lab Corp
Total Cost To Employee: \$150.00	Total Cost To Employee: \$15.00

It pays to take advantage of the Incentive Program! Next time you are considering having any outpatient procedure or imaging done, be sure to check the list of approved providers to help you save!

INCENTIVE PROGRAM FOR PREFERRED PROVIDER SELECTED HOSPITAL AKA Incentive Program

The **Plan** receives greater discounts through the **preferred provider** Selected **Hospital** and **Outpatient Facility** listing:

As an incentive to use one of the exclusive provider **hospitals** and **outpatient facilities**, when a **covered person** utilizes one of the exclusive provider **hospitals** or **outpatient facilities**, the **Plan** will issue a check to the **employee** the amount of the **coinsurance** applied to that **covered expense**.

This benefit is subject to the procedure or **confinement** being a **covered expense** under this **Plan**. This incentive program applies to the **employee** and enrolled **dependents**. The incentive payment shall be issued in the name of the **employee**.

The incentive payment will be issued upon the **claims administrator's** receipt of the claim for the **covered expense**.

The section entitled, *Schedule of Benefits, Preferred Provider Select Hospitals*, shall include the following **providers:**

Desert Ridge Outpatient Surgery Center
20940 N Tatum Blvd #370
PHX 85050
480-502-4010

Metro Surgery Center
6790 W. Thunderbird Rd
Peoria, AZ 85381
623-979-1717

Oasis Hospital
750 N 40th St.
PHX 85008

Canyon Surgery Center
6036 N 19TH Ave #100
PHX 85015

AZ Outpatient Surgery Center
6245 N 16TH St
PHX 85016

The Surgical Hospital of PHX
6501 N 19TH Ave
PHX 85015

Banner Estrella Surgery Center
9301W Thomas Rd
Phoenix, AZ 85037
(623) 388-5700

Phoenix Orthopedic Ambulatory
690 N Cofco Center Ct Ste 150
Phoenix, AZ 85008
(602) 288-4476

Outpatient Surgical Care
1530 W Glendale Ave Ste105
Phoenix, AZ 85021
(602) 995-3395

Peoria Surgery Center
13260 North 94th Drive Suite 200
Peoria, Arizona 85381
Phone: (623) 933-2900

Northwest Tucson Surgery Center AKA Northwest Hospital
(520) 877-6700
6320 N. La Challa Blvd., Suite 100
Tucson, AZ 85741

Oro Valley Hospital
(520) 901-3500
1551E. Tangerine Road
Oro Valley, AZ 85755

Carondelet Foothills Surgery Center
(520) 877-5660
2220 W. Orange Grove Road
Tucson, AZ 85741

US Plan Medical		US Plan BCBS Present Plan		US Plan BCBS Renewal Plan	
Out of Pocket Maximums		In Network	Out of Network	In Network	Out of Network
Individual (In/Out)		\$5,500	\$20,000	\$5,500	\$20,000
Family (In/Out)		\$11,000	\$40,000	\$11,000	\$40,000
Deductible					
Individual (In/Out)		\$750	\$1,500	\$750	\$1,500
Family (In/Out)		\$1,500	\$3,000	\$1,500	\$3,000
Coinsurance					
Office Visit/Specialist		80% + deductible	60% + deductible	80% + deductible	60% + deductible
X-Ray and Lab's		\$15 Copay	60% + deductible	\$15 Copay	60% + deductible
Routine Labs - Primary/Specialist		\$15/\$25 Copay	60% + deductible	\$15/\$25 Copay	60% + deductible
Contracted Provider		80% + deductible	60% + deductible	\$15 Copay	60% + deductible
Hospital and non-Contracted Provider		80% + deductible	60% + deductible	80% + deductible	60% + deductible
Complex Imaging MRI, CT, Pet Scan's etc					
Contracted Provider		80% + deductible	60% + deductible	\$25	60% + deductible
Hospital and non-Contracted Provider		80% + deductible	60% + deductible	80% + deductible	60% + deductible
Rehabilitation 60 Visits		80% + deductible	60% + deductible	\$30 Copay	60% + deductible
combined Physical, Speech, Occupational, Pulmonary, Cardiac, Chiropractic					
Incentive Plan					
Reimbursement Logging - Select Providers		N/A	N/A	Up to \$125 per night up to 4 nights	Not Covered
Hospital and Outpatient - Select Providers		N/A	N/A	100% + deductible	Not Covered
Prescriptions		\$5/\$35/\$55	Not Covered	\$5/\$35/\$55	Not Covered
Mail Order Pharmacy (90 Days)		\$15/\$75/\$135	Not Covered	\$15/\$75/\$135	Not Covered
Emergency Room		80% + deductible	80% + deductible	80% + deductible	80% + deductible
Urgent Care		\$30 Copay	60% + deductible	\$30 Copay	60% + deductible
Hospital		80% + deductible	60% + deductible	80% + deductible	60% + deductible
Out Patient Surgery		80% + deductible	60% + deductible	80% + deductible	60% + deductible
Ambulance		80% + deductible	80% + deductible	80% + deductible	80% + deductible
Behavioral/Mental Health Services					
Inpatient		80% + deductible	60% + deductible	80% + deductible	60% + deductible
Outpatient		\$15 Copay	60% + deductible	\$15 Copay	60% + deductible
Rate Guarantee Period		12 Months		12 Months	
Annual Maximums		Unlimited		Unlimited	
Network		BCBS		BCBS	
Rates:		Four Tier		Four Tier	
Employee	123	\$636.67		\$636.67	
Employee + Spouse	5	\$1,321.22		\$1,321.22	
Employee+ Child	42	\$1,321.22		\$1,321.22	
Family	22	\$2,021.09		\$2,021.09	
Monthly Premium	192	\$184,871.73		\$184,871.73	
Annual Premium		\$2,218,460.76		\$2,218,460.76	
Percentage Change				0.00%	

*Failure to obtain precertification for inpatient hospital, outpatient surgery, non-emergency hospital admissions, and skilled nursing facilities

Incentive Plan reimbursement does not accumulate toward out of pocket or deductible

shall result in a reduction of the plan's coinsurance to 50% for such covered expenses.

*Insured is responsible for balance bill on out-of-network services

Mexico Medical Plan Medical		Mexico Plan Siarmed Present Plan		Mexico Plan Siarmed Renewal Plan	
Out of Pocket Maximums		In Network	Out of Network	In Network	Out of Network
Individual (In/Out)		\$6,250	\$20,000	\$6,250	\$20,000
Family (In/Out)		\$12,500	\$40,000	\$12,500	\$40,000
Deductible					
Individual (In/Out)		\$0	\$0	\$0	\$0
Family (In/Out)		\$0	\$0	\$0	\$0
Coinsurance					
Office Visit/Specialist		100%	50%	100%	50%
Diagnostic Labs		\$5 Copay	50%	\$5 Copay	50%
Contracted Facilities					
Radiology (MRI, MRA, CT, PET)		\$10 Copay	50%	\$10 Copay	50%
Preventative - Lab & Radiology		\$25 Copay	50%	\$25 Copay	50%
		\$5 Copay	50%	\$5 Copay	50%
Prescriptions					
Mail Order Pharmacy (90 Days)		\$3/\$6 Copay	50%	\$3/\$6 Copay	50%
		N/A	N/A	N/A	N/A
Emergency Room		\$250 Copay	\$250 Copay	\$50 Copay	\$50 Copay
Urgent Care		\$20 Copay	50%	\$20 Copay	50%
Hospital		\$50 Copay	50%	\$50 Copay	50%
Out Patient Surgery		\$25 Copay	50%	\$25 Copay	50%
Ambulance		N/A	50%	N/A	50%
Behavioral/Mental Health Services					
Inpatient		Not available	50%	Not available	50%
Outpatient		\$5 Copay	50%	\$5 Copay	50%
Rate Guarantee Period		12 Months		12 Months	
Annual Maximums		Unlimited		Unlimited	
		Siarmed		Siarmed	
Network		Four Tier		Four Tier	
Employee	1	\$232.00		\$232.00	
Employee + Spouse	5	\$481.39		\$481.39	
Employee+ Child	10	\$481.39		\$481.39	
Family	24	\$702.95		\$702.95	
Monthly Premium	40	\$24,323.65		\$24,323.65	
Annual Premium		\$291,883.80		\$291,883.80	
Percentage Change				0.0%	

*Insured is responsible for balance bill on out-of-network services

*Out of Network in Mexico available with Stop Loss carrier approval

*Out of Network will be available in Mexico with approval from the Stop Loss Carrier for Emergency Only

Vision Renewal Rates		Vision Service Plan		Vision Service Plan	
		Current		Renewal;	
		In Network	Out of Network	In Network	Out of Network
Exam Copay		\$10	Up to \$50	\$10	Up to \$50
Frames		\$25	Up to \$70	\$25	Up to \$70
Contact Exam		Up to \$60	N/A	Up to \$60	N/A
Standard Lenses (pair)					
Single		100%	Up to \$50	100%	Up to \$50
Bifocal		100%	Up to \$75	100%	Up to \$75
Trifocal		100%	Up to \$100	100%	Up to \$100
Lenticular		N/A	N/A	N/A	N/A
Progressive (standard)		100%	Up to \$75	100%	Up to \$75
Elective Contact Lenses		Coverage Up to \$130	Up to \$105	Coverage Up to \$130	Up to \$105
Necessary Contact lenses		100%	Up to \$105	100%	Up to \$105
Contact Allowance in lieu of glasses		\$130	Up to \$60	\$130	Up to \$60
LASIK Benefit		Up to 15% Discount	N/A	Up to 15% Discount	N/A
Coverage for Dependents		Up to 26 requires Student Status		Up to 26 requires Student Status	
Frequency					
Exam		12 Months		12 Months	
Lenses		12 Months		12 Months	
Frames		12 Months		12 Months	
Contacts		12 Months		12 Months	
Network		VSP		VSP	
Rate Guarantee				6/30/2023	
RATES:		Two Tier		Two Tier	
Employee Only	143	\$10.70		\$10.91	
Family	96	\$23.00		\$23.46	
Total Monthly Premium	239	\$3,738.10		\$3,812.29	
Annual Premium		\$44,857.20		\$45,747.48	
Percentage Change				1.98%	

*Only one co-pay applies either the materials or the frames, if both services are being received only one co-pay applies.

*Contact lenses are in lieu of glasses
Contracted was negotiated for 4 years

US Mexico and Mexico Dental only Plans

Dental Benefits		US/MX Coverage			Siarned Mexico Coverage	
		Present	Renewal		Current	Renewal
DEDUCTIBLE					No Out of Network Benefits	No Out of Network Benefits
Individual		\$25	\$25		\$0	\$0
Family		\$50	\$50		\$0	\$0
MAXIMUM ANNUAL BENEFIT						
Orthodontics - Lifetime Max		\$2,000	\$2,000		\$1,000	\$1,000
Orthodontics - Children 19 and under per person		\$2,000	\$2,000		\$1,000	\$1,000
COINSURANCE		50%	50%		50%	50%
Preventive Service						
Basic Services		100%	100%		\$10 Copay	\$10 Copay
Major Services		80%	80%		\$20 Copay	\$20 Copay
Orthodontics		50%	50%		\$50 Copay	\$50 Copay
\$1,000 Lifetime Maximum		50%	50%		50%	50%
RX						
Rate Guarantee		N/A	N/A		N/A	\$3/\$6
RATES:		12 Months	12 Months		12 Months	12 Months
		Four Tier	Four Tier		Four Tier	Four Tier
Employee	127	\$37.60	\$37.60	0	\$16.78	\$16.78
Employee&Spouse	5	\$75.19	\$75.10	9	\$33.55	\$33.55
Employee & Children	28	\$75.19	\$75.19	16	\$33.55	\$33.55
Family	24	\$93.85	\$93.85	29	\$44.73	\$44.73
Total Monthly Premium	184	\$9,508.87	\$9,508.42	54	\$2,135.92	\$2,135.92
Annual Premium		\$114,106.44	\$114,101.04		\$25,631.04	\$25,631.04
Annual Difference			0.00%			0.00%

*Lifetime Maximum - Dependents must be covered under plan for 12 consecutive months before orthodontia is available

*US Dental Coverage allows for coverage in Mexico

***There is no Out of Network coverage on the Mexico Only Plan**

*Deductible applies for Basic, Major and Ortho services in the US

Rx was added to the Mexico plan which is the same as the medical plan

City of San Luis Current / Renewal Basic Life and AD&D - No Change

Benefits	Current and Renewal		
Eligibility	All Employees		
Life Insurance Benefit	1 X Salary to \$50,000		
Basic AD&D	1 X Salary to \$50,000		
Rate Guarantee	6/30/2017		
	Volume	Rates per \$1,000	Monthly Premium
Life Amount		\$0.15	\$1,403.60
AD&D Amount	\$9,357,336	\$0.04	\$374.29
Estimated Annual Premium		\$21,334.73	
Total Change from Current (%)		\$0	
Total Change from Current (\$)		\$0	
Guarantee		2 Year	

Coverage decreases by 35% at age 70 and 50% at age 75

Guarantee is from 7/1/2019 to 6/30/2021

City of San Luis Current / Renewal Long Term Disability - No Change

Benefits		The Standard - CURRENT and Renewal	
Class/ Eligibility		Public Safety Only	
Weekly Benefit		60% of 1st \$16,667	
Maximum Monthly Benefit		\$10,000	
Accident Benefit Begin On Day		181	
Sickness Benefit Begin on Day		181	
Maximum Benefit Period		To age 65	
Employee Assistance Program		Included	
Rate Guarantee			
Volume		Rates per \$100	Monthly Premium
\$214,320		\$0.25	\$535.80
Estimated Annual Premium			\$6,430
Salary			
Total Change from Current (%)		No Change	
Total Change from Current (\$)			
Guarantee		2 year Guarantee	

*Benefit decrease after age 62 or continues to age 65/Social Security age

Guarantee is from 7/1/2019 to 6/30/2021

Rates and Benefits represent only a summary of benefits and rates. Refer to plan document, SBCs and Summaries for details.

City of San Luis Current / Renewal Short Term Disability

Benefits	Current and Renewal		Option 1		Option 2	
Eligibility	All Employees		All Employees		All Employees	
Maximum Weekly Benefit	\$2,000		\$2,000		\$2,000	
Accident Benefit Begins on Day	15		15		15	
Sickness Benefit Begins on Day	15		15		15	
Maximum Benefit Duration	180 days		180 days		180 days	
Benefit Percentage	66.67%		66.67%		66.67%	
Off-set Definition	See Below		See Below		See Below	
Rate Guarantee	6/30/2019		6/30/2019		6/30/2019	
Volume	Rates per \$10	Monthly Premium	Rates per \$10	Monthly Premium	Rates per \$10	Monthly Premium
\$116,544	\$0.423	\$4,929.81	\$0.480	\$5,594.11	\$0.580	\$6,759.55
	Annual Premium		Annual Premium		Annual Premium	
	\$59,157.73		\$67,129.34		\$81,114.62	
Total Change from Current (%)	No Change		\$7,971.61		\$21,956.89	
Total Change from Current (\$)			13.48%		37.12%	
Guarantee	2 years		2 years		2 years	

*The STD rate increased from \$0.39 to \$0.423 effective 1/1/2017 to add FICA services to the account
In Second year guarantee

Current plan - No Choice - income offset - all income including sick leave, donated time, other disability, retirement income except vacation

Option plan 1 - Member Choice - can choose either STD Benefits or Sick Leave as benefit, Off-set is other income except vacation

Option plan 2 - Back door Integration - member can take Sick Leave plus STD Benefits up to 100% of income but not more - exception vacation

Transwestern Mexico Voluntary Medical			
Product Description		Current	Renewal
Admin Fee		\$20.25	\$20.50
Broker Fee		\$5.00	\$5.00
Mexico Panel		\$1.00	\$1.00
Hospital Santa Margarita		\$70.00	\$70.00
Total Fixed Costs		\$96.25	\$96.50
Total Monthly Premium	2	\$192.50	\$193.00
Annual Premium		\$385.00	\$386.00
Annual Premium		\$4,620.00	\$4,632.00
Percentage Increase			0.26%
Cobra Rates		\$228.48	\$228.74

City of San Luis
2019-2020 Rates and Contributions

Benefit Type	Coverage	Premium	Employer Cost	Employee Cost	
Which Benefit	Who's Covered	Monthly	Monthly	Monthly	Per Pay Check (24)
<u>Medical</u>– US & Mexico (Mayo/ BCBS)	Employee Only	\$636.67	\$636.67	\$0.00	\$0.00
	Employee & Spouse	\$1,321.22	\$1,021.57	\$299.65	\$149.83
	Employee & Child(ren)	\$1,321.22	\$1,021.57	\$299.65	\$149.83
	Family	\$2,021.09	\$1,562.71	\$458.38	\$229.19
<u>Medical</u>– Mexico Only	Employee Only	\$232.00	\$232.00	\$0.00	\$0.00
	Employee & Spouse	\$481.39	\$372.21	\$109.18	\$54.59
	Employee & Child(ren)	\$481.39	\$372.21	\$109.18	\$54.59
	Family	\$702.95	\$543.52	\$159.43	\$79.71
<u>Dental</u>– US & Mexico	Employee Only	\$37.60	\$37.60	\$0.00	\$0.00
	Employee & Spouse	\$75.19	\$32.87	\$42.32	\$21.16
	Employee & Child(ren)	\$75.19	\$32.87	\$42.32	\$21.16
	Family	\$93.85	\$41.03	\$52.82	\$26.41
<u>Dental</u> – Mexico Only (Siarmed)	Employee Only	\$16.78	\$16.78	\$0.00	\$0.00
	Employee & Spouse	\$33.55	\$14.67	\$18.88	\$9.44
	Employee & Child(ren)	\$33.55	\$14.67	\$18.88	\$9.44
	Family	\$44.73	\$19.55	\$25.18	\$12.59
VSP-Vision Service Plan	Employee Only	\$10.91	\$10.91	\$0.00	\$0.00
	Family	\$23.46	\$10.91	\$12.55	\$6.28
Healthiest You	Employee	\$8.00	\$8.00	\$0.00	\$0.00
	Family	\$0.00	\$0.00	\$0.00	\$0.00
Standard Basic Life & AD&D Insurance	1x Salary up to \$50,000	\$ 0.19 per \$1,000 of annual salary	\$ 0.19 per \$1,000 of annual salary	\$0.00	\$0.00
Standard Short-term Disability	All Employees	\$ 0.423 per \$10 of annual salary	\$ 0.423 per \$10 of annual salary	\$0.00	\$0.00
Standard Long-term Disability	Public Safety Employees	\$0.25 per \$100 of monthly salary	\$0.25 per \$100 of monthly salary	\$0.00	\$0.00
Transwestern Voluntary MX Medical Insurance	Family	\$96.00	\$0.00	\$96.00	\$48.00
Employee Assistance Program	Public Safety Employees	Included with Standard Benefits	\$0.00	\$0.00	\$0.00
EAP Preferred	All Employees	\$2.28	\$2.28	\$0.00	\$0.00

Proposed rates for 7/1/2019 - 6/30/2020

2019-2020 Contribution Assumptions				
MEDICAL	EE Only	EE/Spouse	EE/Children	Family
US & Mexico				
Employer %	100.00%	77.23%	77.32%	77.32%
Employee %	0.00%	22.77%	22.68%	22.68%
Mexico				
Employer %	100.00%	77.32%	77.32%	77.32%
Employee %	0.00%	22.68%	22.68%	22.68%
DENTAL				
US & Mexico				
Employer %	100.00%	43.72%	43.72%	43.71%
Employee %	0.00%	56.28%	56.28%	56.29%
Mexico				
Employer %	100.00%	43.73%	43.73%	43.73%
Employee %	0.00%	56.27%	56.27%	56.27%
VISION				
Employer %	100.00%	N/A	N/A	46.52%
Employee %	0.00%	N/A	N/A	53.48%

Current Premium Rates 07-01-2018 to 6-30-2019

Coverage	Enrollment Tier	Medical Rate	Medical Premium	Employer Contribution Medical	Employee Contribution Medical	Dental Rate	Dental Premium	Employer Contribution Dental	Employee Contribution Dental	Vision Rate	Vision Premium	Employer Contribution Vision	Employee Contribution Vision
Medical, Dental & Vision	US & Mexico-Employee Cost	\$ 636.67	\$ 78,310.41	\$ 78,310.41	\$ -	\$ 37.60	\$ 4,775.20	\$ 4,775.20	\$ -	\$ 10.70	\$ 1,530.10	\$ 1,530.10	\$ -
Medical, Dental & Vision	US & Mexico-Spouse Cost	\$ 1,321.22	\$ 6,606.10	\$ 5,107.84	\$ 1,498.26	\$ 75.19	\$ 375.95	\$ 164.37	\$ 211.58				
Medical, Dental & Vision	US & Mexico-Child(ren) Cost	\$ 1,321.22	\$ 55,491.24	\$ 42,905.83	\$ 12,585.41	\$ 75.19	\$ 2,105.32	\$ 920.45	\$ 1,184.87				
Medical, Dental & Vision	US & Mexico-Spouse & Child(ren) Cost	\$ 2,021.09	\$ 44,463.98	\$ 34,379.55	\$ 10,084.43	\$ 93.85	\$ 2,252.40	\$ 984.52	\$ 1,267.88	\$ 23.00	\$ 2,208.00	\$ 1,027.16	\$ 1,180.84
Medical, Dental & Vision	Mexico-Employee	\$ 232.00	\$ 232.00	\$ 232.00	\$ -	\$ 16.78	\$ -	\$ -	\$ -				
Medical, Dental & Vision	Mexico-Employee & Spouse	\$ 481.39	\$ 2,406.95	\$ 1,861.05	\$ 545.90	\$ 33.55	\$ 301.95	\$ 132.04	\$ 169.91				
Medical, Dental & Vision	Mexico-Employee & Children	\$ 481.39	\$ 4,813.90	\$ 3,722.11	\$ 1,091.79	\$ 33.55	\$ 536.80	\$ 234.74	\$ 302.06				
Medical, Dental & Vision	Mexico-Emp, Spouse & Child(ren) Cost	\$ 702.95	\$ 16,870.80	\$ 13,044.50	\$ 3,826.30	\$ 44.73	\$ 1,297.17	\$ 567.25	\$ 729.92				
	Monthly Premium Totals		\$ 209,195.38	\$ 179,563.29	\$ 29,632.09		\$ 11,644.79	\$ 7,778.57	\$ 3,866.22		\$ 3,738.10	\$ 1,738.96	\$ 1,999.14
	Annual Premium Totals		\$ 2,510,344.56	\$ 2,154,759.44	\$ 355,585.12		\$ 139,737.48	\$ 93,342.88	\$ 46,394.60		\$ 44,857.20	\$ 20,867.57	\$ 23,989.63
Combined Monthly Total	\$ 224,578.27												
Employer Contribution Monthly	\$ 189,080.82												
Other	\$ 109,962.00												
Annual Total	\$ 2,804,901.24												

Changes from Current:	
Dollar Change	
Percent Change	

Enrollment Counts	Medical	Dental	Healthiest You	Vision
US-Single	123	127	234	143
US-Employee + Spouse	5	5		
US-Employee + Child(ren)	42	28		
US-Family	22	24		96
MX-Single	1	0		
MX-Employee + Spouse	5	9		
MX-Employee + Child(ren)	10	16		
MX-Family	24	29		
	232	238		239

Healthiest You \$8.00 PEPM (240E)	\$23,040		
Short Term Disability	\$59,157.73		
Long Term Disability	\$6,430.00		
Basic Life Insurance	\$21,334.73	Total	\$109,962

2018-2019 Contribution Assumptions				
MEDICAL	EE Only	EE/Spouse	EE/Children	Family
US & Mexico				
Employer %	100.00%	77.32%	77.32%	77.32%
Employee %	0.00%	22.68%	22.68%	22.68%
Mexico				
Employer %	100.00%	77.32%	77.32%	77.32%
Employee %	0.00%	22.68%	22.68%	22.68%
DENTAL	EE Only	EE/Spouse	EE/Children	Family
US & Mexico				
Employer %	100.00%	43.72%	43.72%	43.71%
Employee %	0.00%	56.28%	56.28%	56.29%
Mexico				
Employer %	100.00%	43.73%	43.73%	43.73%
Employee %	0.00%	56.27%	56.27%	56.27%
VISION	EE Only	EE/Spouse	EE/Children	Family
Employer %	100.00%	N/A	N/A	46.52%
Employee %	0.00%	N/A	N/A	53.48%

Contribution Comparison 2018-2019 - 2019 - 2020

Contribution Changes Employee Benefits - Employer (ER), Employee (EE)

	Current Plan			Renewal Option				
	2018-2019 Total Premium	2018-2019 ER Contribution	2018-2019 EE Contribution	2019-2020 Total Premium	2019-2020 ER Contribution	2019-2020 EE Contribution	ER Difference Contribution	% Change
Medical (US & Mex)	\$ 2,510,344.56	\$ 2,154,759.44	\$ 355,585.12	\$ 2,510,344.56	\$ 2,154,688.09	\$ 355,656.47	\$ (71.35)	0.00%
Dental (US & Mex)	\$ 139,737.48	\$ 93,342.88	\$ 46,394.60	\$ 139,737.48	\$ 93,342.88	\$ 46,394.60	\$ -	0.00%
Vision	\$ 44,857.20	\$ 20,867.57	\$ 23,989.63	\$ 45,747.48	\$ 21,281.73	\$ 24,465.75	\$ 414.16	1.98%
Short Term Disability	\$59,157.73	\$ 59,157.73	\$ -	\$81,114.62	\$ 81,114.62	\$ -	\$ 21,956.89	37.12%
Long Term Disability	\$6,430.00	\$ 6,430.00	\$ -	\$6,430.00	\$ 6,430.00	\$ -	\$ -	0.00%
Basic Life	\$21,334.73	\$ 21,334.73	\$ -	\$21,334.73	\$ 21,334.73	\$ -	\$ -	0.00%
Transwestern (Not Included in Budget)	\$ 2,310.00	\$ -		\$2,316	\$ -			0.00%
Total Budget Requirements	\$ 2,784,171.70	\$ 2,355,892.34	\$ 425,969.36	\$ 2,807,024.87	\$ 2,378,192.05	\$ 426,516.82	\$ 22,299.70	0.94%

Premium Increases	\$	%
Medical Premium (US & Mexico)	\$0.00	0.00%
Dental Premium	\$0.00	0.00%
Life, STD, LTD Premium	\$21,956.89	25.26%

Summary

Medical	Increase in Total Premium	\$0.00
	Employer Portion	-\$71.35
	Employee Portion	\$71.35
Dental	Increase in Total Premium	\$0.00
	Employer Portion	\$0.00
	Employee Portion	\$0.00
Total Changes:	All Benefits	\$22,853.17
	ER	\$22,299.70
	EE	\$547.47



February 28, 2019

TADEO DELAHOYA
CITY OF SAN LUIS
1090 E UNION ST
SAN LUIS, AZ 85349

DEAR TADEO DELAHOYA:

Thank you for choosing VSP® Vision Care — and for your continued business. Putting your employees first and guaranteeing their satisfaction is easy, when we have partners like you.

As the only national not-for-profit vision company, we're committed to giving your employees:

- **Lowest employee out-of-pocket costs** — employees' #1 priority in a vision plan.
- **Exclusive Member Extras.** offers you won't find anywhere else — only VSP members can save more than \$2,500 on vision, hearing, medical, and lifestyle services.
- **World class service** — the highest customer satisfaction in the industry, 15 years in a row.

Your VSP plan automatically renews on **July 1, 2019** and **no action is required** to continue to receive consumers' **#1** choice in vision care.

Group Name/Number: CITY OF SAN LUIS / 12131573
Renewal Period: July 1, 2019 - June 30, 2023
Current Plan Frequency: 12 / 12 / 12
Current Copay: \$10 Exam / \$25 Materials
Current Allowance: \$130.00 Retail Frame / \$130.00 Elective Contact Lenses
Current Rates: \$10.70 / 23.00
Renewal Rates: \$10.91 / 23.46
Rates include all applicable taxes and health assessment fees known as of the date of your renewal.

Enhanced Offering

Have you considered **upgrading your Plan Frequency** or **increasing your Retail Frame Allowance** to maximize the lowest out-of-pocket for your employees? We recommend these enhancements when you renew your current plan to deliver greater value:

Plan Frequency: 12 / 12 / 12
Copay: \$10.00 Exam / \$25.00 Materials
Allowance: \$150.00 Retail Frame / \$130.00 Elective Contact Lenses
Renewal Rates: \$11.29 / 24.26

Updating your plan is simple! Give me a call to enhance your benefits or to lower your premium and keep delivering the lowest out-of-pocket costs.

Thank you,

John Loudaros (800) 216-6248

cc: SUSAN A. POSADA
82 W WINDSOR AVE
PHOENIX, AZ 85003

Central Team



Request for Group Insurance Amendment

Standard Insurance Company
900 SW Fifth Avenue
Portland, OR 97204-1282

Employee Benefits Consultant: David Weinstein
Employee Benefits Service Representative: Valerie Piele
Employee Benefits Sales and Service Office: Los Angeles

Policyholder: CITY OF SAN LUIS
Group Number: 618359

As an authorized representative of the Employer, I request that Standard Insurance Company ("The Standard") amend the above Employer's coverage under the Group Policy to make the following change(s):

Amend Short Term Disability to Include 100% Backdoor Integration. New rate is \$0.58 per \$10 of Benefit

I request that the amendment become effective on 07/01/2019. I understand that the amendment will not become effective unless approved and issued by The Standard.

I request that the amendment be approved by The Standard subject to The Standard's usual underwriting requirements, including, if applicable, Evidence of Insurability or a Pre-existing Condition provision.

I understand that the amendment, if approved by The Standard, will be issued in the policy language customarily used by The Standard.

I understand that any increase in Insurance for a Member who is not Actively At Work all day on the Member's last regular work day before the scheduled effective date of the amendment will be deferred until the first day after the Member completes one full day of Active Work.

I request that the amendment, if approved and issued by The Standard, become effective by its terms without any further acceptance by the Employer, and that a copy of this Request for Group Insurance Amendment form be attached to and made a part of the amendment.

Sign Name: _____ Title: _____
Authorized Representative

Print Name: _____ Date: _____



City of San Luis
2019 Renewal Summary
Policy 618359

Thank you for choosing Standard Insurance Company (The Standard) as your employee benefits partner since October 1, 1994. We appreciate your business and the opportunity to renew our commitment. We strive to provide Critical Path Institute and your employees outstanding value, expertise and personal service.

As always, our goal is to help you take care of your business and your employees. Our team remains committed to helping you achieve strategic goals for your benefits program, streamline administration and increase employee satisfaction. In short — better results with less noise. Thank you again for your continued business.

We appreciate the opportunity to continue our partnership with City of San Luis.

A summary of our Renewal Offer is in the chart below. Thank you for allowing Standard Insurance Company the opportunity to support your insurance needs.

Product & Services *	Through 06/30/19	Effective 07/01/19
Basic Life	\$0.150 Per \$1000 of Benefit	\$0.150 Per \$1000 of Benefit
Basic AD&D	\$0.040 Per \$1000 of Benefit	\$0.050 Per \$1000 of Benefit
Additional Life	Rate Varies	Rate Varies, No Change
Additional AD&D	\$0.040 Per \$1000 of Benefit	\$0.040 Per \$1000 of Benefit
Spouse Dependent Life	Rate Varies	Rate Varies, No Change
Spouse Dependent AD&D	\$0.040 Per \$1000, Elective	\$0.040 Per \$1000, Elective
Child Dependent Life	\$0.200 Per \$1000, Elective	\$0.200 Per \$1000, Elective
Child Dependent AD&D	\$0.040 Per \$1000, Elective	\$0.040 Per \$1000, Elective
LTD	\$0.250 Percent of Insured Earnings	\$0.250 Percent of Insured Earnings
Employee Assistance Program	Included in Rates for LTD	Included in Rates for LTD
STD	\$0.423 Per \$10.00 of Benefit	\$0.423 Per \$10.00 of Benefit

* The above shown rates are monthly

You can count on us to help you retain and attract employees by providing the benefits and services they value – now and for years to come. We're always available to address any questions you have about this renewal or for any service needs. Please reach out to the Los Angeles group office at (602) 328-2101 and we'll be happy to help.



AGENDA ITEM REVIEW FORM

Special City Council Meeting

5.E.

Meeting Date: 06/25/2019

Department Head: Kay Macuil, City Attorney, Attorney's Office

Submitted By: Kay Macuil, City Attorney, Attorney's Office

Action Requested: Motion
Order

ITEM:

Discussion and possible action on any and all matters regarding Order No. 2019-7. An order of the Mayor and City Council of the City of San Luis, Arizona declaring the Employee Benefits Plans a public record; approving the Employee Benefits Plans for the fiscal year 2019-2020 for administration by the San Luis Employee Benefits Trust; providing for repeal of conflicting actions of City Council; providing for severability; and establishing an effective date for the plans. **(Edgardo Carbajal, HR Recruitment Coordinator and Maria Muñoz, HR Benefits Coordinator)**

SUMMARY:

The PowerPoint presentation from the Budget Meeting on April 26, 2019 (2019 Renewal Presentation), the Benefit Plan Documents and the 2019 amendments are attached.

Background

Consultant and Benefits Broker Susan Posada negotiated the Employee Benefits Plans for the 2019 - 2020 Fiscal Year.

At the April 26, 2019, Budget Meeting of the City Council, Ms. Posada and EBSO Representative Robert Flunker presented a summary of the plans. The presentation included a detailed PowerPoint advising the City Council of the benefits proposed for the employees' benefit plans the costs involved and historical cost comparisons.

The amount allocated in the final budget for the benefits plan is \$2,662,400.00

Recommendation of the Trust and Staff

The final plan went to the San Luis Employees Benefits Trust on April 24, 2019, and the Trustees approved plan changes that were presented to City Council on April 26, 2019, at the budget meeting. The benefit plans and the amendments for the 2019-2020 fiscal year are attached to this agenda item.

Staff recommends approval of the employees' benefit plans to be administered by the San Luis Employee Benefits Trust and City Staff for the Fiscal Year 2019-2020 and to make it effective on July 1, 2019

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE ORDER NO. 2019-7.

The Amendment to the U.S. Plan and the WinWin program will be provided at the time of the meeting.

Fiscal Impact

IS THERE FISCAL IMPACT ASSOCIATED WITH THIS ITEM: N/A
CITY/STATE/FEDERAL FUNDS: N/A
TOTAL: N/A
BUDGETED AMOUNT: N/A
AVAILABLE AMOUNT TO TRANSFER: N/A
ACCT NAME & GL#/REMAINING BALANCE BEFORE PURCHASE: N/A

FISCAL IMPACT STATEMENT (IF THIS IS A BUDGET TRANSFER, YOU MUST ATTACH THE BUDGET ADJUSTMENT FORM):

This item is the approval of the 2018-2019 Employee Benefits Plan only. The allocation of \$2, 653,910 to the Trust Fund was passed as part of the final budget for Fiscal Year 2018-2019.

Attachments

Order No. 2019-7
2019 Renewal Presentation
US Medical Plan
Amend #1 US Medical Plan
US Dental Plan
Amend #1 US Dental Plan
Mexico Medical Plan
Amend #1 Mexico Medical Plan
Mexico Dental Plan
Amend #1 Mexico Dental Plan



Order

No. 2019-7

OFFICE OF THE
MAYOR
CITY OF SAN LUIS

AN ORDER OF THE MAYOR AND CITY COUNCIL OF THE CITY OF SAN LUIS, ARIZONA DECLARING THE EMPLOYEE BENEFITS PLANS A PUBLIC RECORD; APPROVING THE EMPLOYEE BENEFITS PLANS FOR THE FISCAL YEAR 2019-2020 FOR ADMINISTRATION BY THE SAN LUIS EMPLOYEE BENEFITS TRUST; PROVIDING FOR REPEAL OF CONFLICTING ACTIONS OF CITY COUNCIL; PROVIDING FOR SEVERABILITY; AND ESTABLISHING AN EFFECTIVE DATE FOR THE PLANS.

WHEREAS, the City of San Luis is self-insured, and in 2011, it created the San Luis Employee Benefits Trust to assure the stability and security of funding for employee benefits; and

WHEREAS, the City Council charged the Board of Trustees of San Luis Employee Benefits Trust with administering the trust fund to provide health care, dental care and other benefits to the city's employees and their dependents and to make financial recommendations to the City Manager; and

WHEREAS, City Council provided for the proper publication and notice and held a public hearing on the City's entire budget for the upcoming fiscal year; and

WHEREAS, on June 25, 2019, City Council estimated amounts required to meet public expenditures which included the costs of the employee benefits plans adopted and recommended by the San Luis Employee Benefits Trust for the ensuing year; and

WHEREAS, City Council allocated the estimated cost of **\$2,662,400.00** to the San Luis Employee Benefit Trust to implement said employee benefits plans for the fiscal year 2019-2020.

THEREFORE IT IS ORDERED by the City Council of the City of San Luis as follows:

Section 1. Declaring Public Records: The presentation to City Council and the documents making up the Employee Benefits Plan titled:

1. "2019 Renewal Presentation;"
2. "City of San Luis Employee Benefit Trust, Summary Plan Description and Plan Document, EBSO Group Number: SL S001 Effective: July 1, 2018;"
3. "Master Plan Document Amendment #1" (Effective July 1, 2019);

4. "City of San Luis Employee Benefit Trust Dental Benefit Plan, Plan Document and Summary Plan Description, EBSO Group Number: SL S001 Effective: July 1, 2018;"
5. "Master Plan Document Amendment #1 (Dental Plan)" (Effective July 1, 2019);
6. "City of San Luis Employee Benefit Trust – Mexico Coverage, Summary Plan Description and Plan Document, EBSO Group Number: SL S001 Effective: July 1, 2018;"
7. "Master Plan Document Amendment #1" (Mexico Coverage, Effective July 1, 2019);
8. "City of San Luis Employee Benefit Trust Dental Benefit Plan – Mexico Coverage, Plan Document and Summary Plan Description, EBSO Group Number: SL S001 Effective: July 1, 2018" and
9. "Master Plan Document Amendment #1 (Dental - Mexico Coverage)" (Effective July 1, 2019),

three (3) copies of which are on file in the office of the San Luis City Clerk, are hereby declared to be public records, said copies are ordered to remain on file with the San Luis City Clerk.

Section 2. Incorporation by Reference: The above documents comprising the Employee Benefit Plans are incorporated into this order by this reference as if written out in full here.

Section 3. Approving the Employee Benefits Plan: For the fiscal year 2019-2020, the City Council approves the Employee Benefits Plans as recommended by the San Luis Employee Benefits Trust which is on file with the San Luis City Clerk as ordered above and shall be administered through the San Luis Employee Benefits Trust.

Section 4. Repeal: All actions of City Council prior to this order in conflict with this order are repealed, effective as of July 1, 2019.

Section 5. Severability: If any section, sentence, clause, phrase or portion of this order is held to be invalid or unconstitutional by the decision of any court of competent jurisdiction, such decision shall not affect the validity of the remaining portions of this order.

Section 6. Effective Date: The effective date for the Employee Benefits Plans is July 1, 2019.

PASSED AND ADOPTED by the Mayor and City Council of the City of San Luis, Arizona this _____ day of June 2019

Gerardo Sanchez, Mayor

ATTEST:

APPROVED AS TO FORM:

Sonia Cornelio, City Clerk

Kay Macuil, City Attorney



CITY OF
San Luis Arizona
Gateway to the Sea of Cortez

Trust Meeting
2019 Renewal Presentation

For July 1, 2018 to June 30, 2019

Presented by Susan Posada



SUSAN POSADA
AGENCY

Trust Expenses Covered by Trust

1. Stop Loss
2. Third Party Administrative Fees
 - a. Network Fees
 - i. Blue Cross Blue Shield of AZ – US network
 - ii. Siarmed – Mexico network both medical and dental
 - b. Broker Fees
 - c. Flu Shots for Mexico members
 - d. ACA Reporting Fees
 - e. Claims Utilization
 - f. Cobra Fees
 - g. HealthiestYou (Teledoc)
 - h. EAP – All Employees
 - i. ACA fees
3. Overall – Medical and Dental design, and cost
4. Trust Fund Balance

Not included in Trust

1. Vision plan
2. Basic and Voluntary life
3. Short- and Long-term disability
4. Transwestern voluntary medical plan
5. EAP for Public Safety
6. FMLA

City of San Luis
Changes to Plan Costs
Plan Year 7/1/2019 to 6/30/2020

Budget Increase						Percentage Increase
	Total All Benefit	Employer Portion	Employee Portion			
City - Increase	\$890.28	\$414.16	\$476.12			0.03%
City - Increase with STD Option 2	\$29,249.87	\$29,249.87	\$0.00			1.03%
Trust - Increase with EAP only	\$6,402.24	\$6,402.24	\$0.00			

Total Trust Budget based on recommendations \$2,650,082.04
See details in the Contribution Comparison Sheet for 2019 to 2020

Plan Changes						
Service Changes	Annual Premium 2015	Annual Premium 2016	Annual Premium 2017	2018	2019	Rates % change
Stop Loss	\$432,036.36	\$429,267.12	\$434,847.36	\$483,023.64	\$437,532.72	-10.46%
Mayo/EBSO Fees						
Medical	\$18.00	\$18.50	\$18.60	\$24.50	\$24.50	0.00%
Dental	\$2.90	\$2.90	\$2.95	\$3.00	\$3.00	0.00%
Claims Utilization/ACA FEE	\$3.00	\$3.25	\$3.50	\$3.00	\$3.00	0.00%
Cobra Optum	\$0.79	\$0.74	\$0.74	Incl	Incl	Incl
Siarmed						
Medical	\$3.00	\$3.00	\$3.00	\$3.00	\$3.00	0.00%
Dental	\$1.25	\$1.25	\$1.25	\$1.25	\$1.25	0.00%
Broker Fees	\$32.00	\$33.50	\$33.50	\$35.00	\$35.00	0.00%
BCBS Network Fees	\$15	\$15.50	\$15.75	\$16.00	\$17.50	9.38%

- Mexico network changed to Siarmed effective 4/1/2016

- Stop Loss fees are subject to change pending the 4/31/2019/2019 claims reports

** BCBC negotiated the rate for 2 years \$17.50 PEPM

***Siarmed had agreed to a 3 year agreement (to 6/30/2020) with no price changes in the admin fees and provider fees

City of San Luis

Medical and Dental Enrollment Changes

Medical Enrollment				Dental Enrollment		
	February 1, 2018	February 1, 2019	Percentage Change	February 1, 2018	February 1, 2019	Percentage Change
US/Mexico						
Employees Only	123	123	0.00%	124	127	2.42%
Employee & Spouse	7	5	-28.57%	7	5	-28.57%
Employee and Children	42	42	0.00%	42	28	-33.33%
Family	20	22	10.00%	20	23	15.00%
Mexico Only						
Employees Only	1	1	0.00%	4	0	-100.00%
Employee & Spouse	4	5	25.00%	4	9	125.00%
Employee and Children	10	10	0.00%	10	16	60.00%
Family	24	24	0.00%	24	29	20.83%
Total	222	232	4.50%	223	223	0.00%
Average Members	569	518	-8.96%	538	535	-0.56%

2012-2013 EE's 154 total dep. 570

CITY OF SAN LUIS
STOP LOSS AND ADMINISTRATION RENEWAL EFFECTIVE JULY 1, 2019

DESCRIPTION		2018-20199 Current Symetra	2019-2020 Renewal Symetra	2018-2019 Initial Quote Option 1 Symetra	2018-2019 Initial Quote Option 2 Symetra	2018-2019 Initial Quote Option 3 Int'l/Sirius America	2018-2019 Initial Quote Option 4 Int'l/Sirius America	2018-2019 Initial Quote Option 5 Int'l/Sirius America
STOP LOSS POLICY TERMS		\$50,000 Stop Loss	\$50,000 Stop Loss	\$75,000 Stop Loss	\$100,000 Stop Loss	\$50,000 Stop Loss	\$75,000 Stop Loss	\$100,000 Stop Loss
Specific Lifetime Maximum		Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Specific Annual Reimbursement		Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Specific Deductible		\$ 50,000	\$ 50,000	\$ 75,000	\$ 100,000	\$ 50,000	\$ 75,000	\$ 100,000
Specific Contract Basis		Paid	Paid	Paid	Paid	Paid	Paid	24/12
Specific Coverage		Medical	Medical	Medical	Medical	Medical	Medical	Medical
Specific Run-In Limits		N/A	N/A	N/A	N/A	N/A	N/A	N/A
Lasered Individuals		None	None	None	None	None	None	None
Aggregate Maximum		\$ 1,000,000	\$ 1,000,000	\$ 1,000,000	\$ 1,000,000	\$ 1,000,000	\$ 1,000,000	\$ 1,000,000
Aggregate Coverage		Medical & RX Card	Medical & RX Card	Medical & RX Card	Medical & RX Card	Medical & RX Card	Medical & RX Card	Medical & RX Card
Aggregate Contract Basis		Paid	Paid	Paid	Paid	24/112	24/12	24/12
Aggregate Run-In Limits		N/A	N/A	N/A	N/A	N/A	N/A	N/A
Corridor		25%	25%	25%	25%	25%	25%	25%
STOP LOSS PREMIUM								
Specific Premium								
Employee Rate	124	\$ 88.26	\$ 88.26	\$ 68.32	\$ 53.84	124 \$ 91.82	\$ 69.27	\$ 53.46
Employee + Spouse Rate	10	\$ 266.18	\$ 266.18	\$ 210.17	\$ 169.53	10 \$ 201.07	\$ 151.70	\$ 117.07
Employee + Child(ren) Rate	52	\$ 266.18	\$ 266.18	\$ 210.17	\$ 169.53	52 \$ 174.44	\$ 131.61	\$ 101.57
Employee + Spouse + Children Rate	46	\$ 266.18	\$ 266.18	\$ 210.17	\$ 169.53	46 \$ 286.46	\$ 216.12	\$ 166.79
Projected Total Monthly Specific Premium	232	\$ 39,691.68	\$ 39,691.68	\$ 31,170.04	\$ 24,985.40	232 \$ 35,644.42	\$ 26,891.72	\$ 20,753.72
Aggregate Rate PEPM	232	\$ 3.62	\$ 3.62	\$ 3.59	\$ 3.65	232 \$ 3.52	\$ 3.75	\$ 3.89
Projected Monthly Aggregate Premium		\$ 861.84	\$ 839.84	\$ 832.88	\$ 846.80	\$ 816.64	\$ 870.00	\$ 902.48
TOTAL PROJECTED PREMIUM								
Monthly		\$ 40,553.52	\$ 40,531.52	\$ 32,002.92	\$ 25,832.20	\$ 36,461.06	\$ 27,761.72	\$ 21,656.20
Annual		\$ 486,642.24	\$ 486,378.24	\$ 384,035.04	\$ 309,986.40	\$ 437,532.72	\$ 333,140.64	\$ 259,874.40
Percentage of increase over current			-0.05%	-21.08%	-36.30%	-10.09%	-31.54%	-46.60%
MAXIMUM CLAIM FUNDING FACTORS								
Employee	124	\$ 328.71	\$ 318.84	\$ 343.07	\$ 358.69	124 \$ 382.26	\$ 405.94	\$ 422.48
Employee + Spouse	10	\$ 816.84	\$ 792.31	\$ 852.52	\$ 891.35	10 \$ 827.15	\$ 889.00	\$ 925.21
Employee + Children	52	\$ 816.84	\$ 794.31	\$ 852.52	\$ 892.35	52 \$ 726.29	\$ 771.28	\$ 802.70
Employee + Spouse + Child(ren)	46	\$ 816.84	\$ 794.31	\$ 816.84	\$ 816.84	46 \$ 1,192.65	\$ 1,266.52	\$ 887.62
TOTAL PROJECTED MAXIMUM FUNDING								
Monthly		\$ 128,978.76	\$ 125,301.64	\$ 132,971.56	\$ 137,367.90	\$ 148,300.72	\$ 157,593.04	\$ 142,214.60
Annual		\$ 1,547,745.12	\$ 1,503,619.68	\$ 1,595,658.72	\$ 1,648,414.80	\$ 1,779,608.64	\$ 1,891,116.48	\$ 1,706,575.20
Percentage of increase over current			-2.85%	3.10%	6.50%	14.98%	22.19%	10.26%
PROJECTED ADMINISTRATION COSTS								
TPA Claims Administration Fee - Mayo Health	232	\$ 24.50	\$ 24.50	\$ 24.50	\$ 24.50	232 \$ 24.50	\$ 24.50	\$ 24.50
Dental Claims Administration US Mayo Health	238	\$ 3.00	\$ 3.00	\$ 3.00	\$ 3.00	232 \$ 3.00	\$ 3.00	\$ 3.00
ACA 1095/1094 Reporting	268	\$ 3.00	\$ 3.00	\$ 3.00	\$ 3.00	268 \$ 3.00	\$ 3.00	\$ 3.00
PPO Medical Access Fee - BCBS	198	\$ 16.00	\$ 17.50	\$ 17.50	\$ 17.50	198 \$ 17.50	\$ 17.50	\$ 17.50
Mexico Siamed/SSA Medical and Dental Claims Admin.	238	\$ 4.25	\$ 4.25	\$ 4.25	\$ 4.25	238 \$ 4.25	\$ 4.25	\$ 4.25
Total Monthly Administration		\$ 11,381.50	\$ 11,678.50	\$ 11,678.50	\$ 11,678.50	\$ 11,660.50	\$ 11,660.50	\$ 11,660.50
Total Annual Administration		\$ 136,578.00	\$ 140,142.00	\$ 140,142.00	\$ 140,142.00	\$ 139,926.00	\$ 139,926.00	\$ 139,926.00
Patient Centered Research Inst. (Est.)	535	\$ 1,278.65	\$ 1,310.00	\$ 1,310.75	\$ 1,310.75	535 \$ 1,310.75	\$ 1,310.75	\$ 1,310.75
Total Annual ACA fees	535	\$ 1,278.65	\$ 1,310.00	\$ 1,310.75	\$ 1,310.75	535 \$ 1,310.75	\$ 1,310.75	\$ 1,310.75
Total Annual Administration Fees With Reinsurance & PPCORI		\$ 137,856.65	\$ 140,273.00	\$ 141,452.75	\$ 141,452.75	\$ 141,236.75	\$ 141,236.75	\$ 141,236.75
Percentage of Increase/Decrease Over Current			1.8%	2.6%	2.6%	2.5%	2.5%	2.5%
TOTAL PROJECTED PREMIUM, CLAIMS FUNDING & ADMINISTRATION COSTS								
Monthly		\$ 178,410.17	\$ 180,804.52	\$ 173,455.67	\$ 167,284.95	\$ 177,697.81	\$ 168,998.47	\$ 162,892.95
Annual		\$ 2,140,922.04	\$ 2,130,270.92	\$ 2,121,146.51	\$ 2,099,853.95	\$ 2,132,373.72	\$ 2,027,981.64	\$ 1,954,715.40
Percentage of Increase Over Current			-0.50%	-0.92%	-1.92%	-0.40%	-5.28%	-8.70%

- Rates for the Stop Loss and Aggregate are not final until 4/30/2019 BCBS Network fee originally increase to \$17.50 for 1 year - negotiated 2 years for \$17.50

PPCOR fees for 2017 \$2.30 and 2018 \$2.45 for Average number of lives insured

Rates and benefits are illustrative only and represent only a brief summary of the plan highlights. Final rates will be determined from effective date, actual enrollment and/or health conditions. For actual benefits refer to the carrier proposal.

Rates and Benefits represent only a summary of benefits and rates. Refer to plan document, SBCs and Summaries for details.

Stop Loss Change - Risk and Exposure

	2017-2018	2018-2019*	2018-2019*
Large Claims	\$50,000.00	\$50,000.00	\$75,000.00
Number	5	11	11
Total Potential Exposure	\$250,000	\$550,000	\$825,000
Premium	\$486,642	\$437,533	\$333,140
Difference	\$236,642	(\$112,467)	(\$491,860)

* claims are for 8 months

Estimated Fund Balance	
As of 2/28/2019	
Trust Checking	\$1,547,623.26
Trust Savings as of 12/31/2019	\$1,389,093.29
	\$2,936,716.55
Claims Lag	(\$489,030.00)
Incurred but not reported (IBNR)	(\$261,794.46)
Estimated Total	\$2,185,892.09
Expected Liability	\$2,795,256.48
Percentage	78.20%

2019-2020\$ Fund Requirements	
As of 2/28/2019	
Required Funding for 2019 to 2020	\$2,789,098.56
No Increase - Funding level	\$2,650,02.04
Funding (same as prior year)	
Under Funding	\$139,016.52

EAP and Healthiest You

EAP Preferred						
EAP Visits	EE Total	Visits	Cost PEPM	Monthly Total	Yearly Total	Guarantee
Non-Public Safety Employee	154	3	\$2.17	\$334.18	\$4,010.16	6/30/2022
Non-Public Safety Employee	154	6	\$3.05	\$469.70	\$5,636.40	6/30/2022
All Employees	234	6	\$2.28	\$533.52	\$6,402.24	6/30/2022
All Employees	234	12	\$4.45	\$1,041.30	\$12,495.60	6/30/2022
Public Safety	80	12	\$6.30	\$504.00	\$6,048.00	6/30/2021
* Public Safety 2 and 1/2 years is due to initial contract ending 12/31 and changed to coincide with plan year of 7/1						

Rates are for 7/1/2019

The present contract runs to 7/1/2021

Recommend 6 Visits for all employees with the EAPP Traumatic Agreement wit EAP for all Public Safety

- 24-Hour Access
- Referrals and Follow-up
- Legal and Financial Services
- Orientation and Training
- Communication Materials
- Utilization Reporting

On-site Service Rates	EAP Preferred
CISD (Critical Incident Services)	\$275/\$175
Training, SPV Training	\$275/\$175

Healthiest You TeleDoc				
	Employees	Fixed Cost	Monthly Total	Annual Total
PEPM	234	\$8	\$1,872	\$22,464

PEPM: Premium per Employee per Month

This plan has already been approved by the Trust

ACA Reporting

ACA Reporting		EBSO	Basic
	EE Total		
ACA Reporting Fee	238	\$3.00	\$9.25
Set-up Fee			\$250.00
Total Rate Monthly		\$714.00	\$2,201.50
Total Annual Rates		\$8,568.00	\$26,418.00

City of San Luis Recommended Plan Changes for plan year 2019-2020

	Current 2018-2019	Recommended Renewal 2019-2020
US Medical Plan Recommended Changes		
X-Ray and Lab's		
At Primary Care/Specialist	\$15/\$25 Copay	\$15/\$25 Copay
At Contracted Provider i.e. Sonora Quest and Lab Corp	20% + deductible	\$15 Copay
At a hospital	20% + deductible	20% + deductible
Complex Imaging - Mri, CT Pet Scan etc.		
At Contracted Provider i.e. Sonora Quest and Lab Corp	20% + deductible	\$25 Copay
At a hospital - Complex, MRI, CT and Pet Scan		20% + deductible
Hospitalization		
Pre-Certification	Required	Remove Pre-Cert Requirement
CT Scans, PetScans & MRI's	Required	Remove Pre-Cert Requirement
Special Services such as acupuncture, podiatry & TMJ		Remove Pre-Cert Requirement
No Changes		
Deductible		
In-Network Member	\$750	\$750
In-Network Family	\$1,500	\$1,500
No Changes		
Annual Out of Pocket Maximum		
In-Network Member	\$5,500	\$5,500
In-Network Family	\$11,000	\$11,000
Out of Network - Member	\$20,000	\$20,000
Out-of-Network Family	\$40,000	\$40,000

City of San Luis Recommended Mexico Plan Changes for 2019-2020

Mexico Dental Plan		Recommended
	Current	Renewal
	2018-2019	2019-2020
Mexico Dental Plan (As requested by Siarmed)		
Major Restorative Services Charges to the Trust		
D7472 Removal of Torum Palatinus	\$150	\$250
Maximum Out of Pocket (In Network)	\$150	\$250
D7485 Surgical Reduction of Osseous Tuberosity	\$150	\$250
Orthodontic		
D0340 Cephalometric Film	\$28	\$44
D3050 Panoramic Film	N/A	\$44
D0470 Diagnostic Cast	N/A	\$28
D8030 Limited Orthodontic Treatment of Adolescent Denition	N/A	\$500
D8670 Periodic Orhtodontic Treatment Visit Cast Part of Contract	N/a	\$500
Other Internal Changes		
Rx Copay - Charges to Employee		
RX Copay	N/A	\$3/\$6 Copay
Mexico Medical Plan Change		
Emergency Room - In and out of Network	\$250	\$150

City of San Luis Recommended Plan Changes - Incentive Plan for plan year 2019-2020

Incentive Plan	Recommended Change	
	Current 2018-2019	Renewal 2019-2020
US Medical Plan		
Incentive Program		
Reimbursement for Incentive Program		
Coinsurance Trust pays 80% member 20%	20%	20%
Maximum Out of Pocket (In Network)	\$5,500.00	\$5,500.00
In-Patient - Lodging Reimbursement	None	Up to \$125 per night up to 4 nights
Out-Patient - Lodging Reimbursement	None	Up to \$125 per night up to 4 nights
Maximum Out of Pocket (In Network)	\$5,500.00	\$5,500 Plus lodging reimbursements
Hospitalization for Incentive Program		
Hospitalization and Out-patient	20% + deductible	0% + deductible
	Member pays	Member pays
X-Ray and Lab's		
At Primary Care Provider - Diagnostic, X-ray and Lab	\$15 Copay	\$15 Copay
At Secondary Care Provider - Diagnostic, X-ray and Lab	\$25 Copay	\$25 Copay
At Contracted Provider i.e. Sonora Quest and Lab Corp	20% + deductible	\$15 Copay
At an hospital -	20% + deductible	20% + deductible
Complex Imaging - Mri, CT Pet Scan etc.		
At Contracted Provider i.e. Sonora Quest and Lab Corp	20% + deductible	\$25 Copay
At a hospital - Complex, MRI, CT and Pet Scan	20% + deductible	20% + deductible
Out of Network - Member	\$20,000	\$20,000
Out-of-Network Family	\$40,000	\$40,000

City of San Luis Incentive Program Savings Examples

The City of San Luis has created an Incentive Program for employees to help save money on expensive outpatient procedures and imaging. By taking advantage of the facilities listed in the Incentive Program, members can experience significant savings when compared to going to Yuma Regional Hospital and other local outpatient facilities.

Here are some examples of the savings you could experience by using the Incentive Program Facilities.

Example #1:

Procedure needing to be complete: Knee Replacement

Cost To An Employee For Going To Yuma Regional Hospital	Cost To An Employee For Going To Recommended Facility
Deductible: \$750.00	Deductible: \$750.00
Coinsurance Percentage Employee Is Responsible For: 20%	Coinsurance Percentage Employee Is Responsible For: 0%
Coinsurance Estimated Dollar Amount Employee Is Responsible For Before The Out of Pocket Max Is Met: \$4,750.00	Employee Does Not Pay Any Coinsurance For The Knee Replacement
Total Cost To Employee: \$5,500.00	Total Cost To Employee: \$750.00

Example #2:

Procedure needing to be complete: X-Ray of Ankle

Cost To An Employee For Going To Yuma Regional Hospital	Cost To An Employee For Going To Sonora Quest or Lab Corp
Deductible: \$750.00	Deductible: \$750.00
Coinsurance Percentage Employee Is Responsible For: 20%	Copay Dollar Amount Employee Is Responsible For: \$15.00
Coinsurance Estimated Dollar Amount Employee Is Responsible For Before The Out of Pocket Max Is Met: \$0.00 because deductible has not been met yet	Employee Does Not Pay Any Coinsurance For an X-Ray when going to Sonora Quest or Lab Corp
Total Cost To Employee: \$150.00	Total Cost To Employee: \$15.00

It pays to take advantage of the Incentive Program! Next time you are considering having any outpatient procedure or imaging done, be sure to check the list of approved providers to help you save!

INCENTIVE PROGRAM FOR PREFERRED PROVIDER SELECTED HOSPITAL AKA Incentive Program

The **Plan** receives greater discounts through the **preferred provider** Selected **Hospital** and **Outpatient Facility** listing:

As an incentive to use one of the exclusive provider **hospitals** and **outpatient facilities**, when a **covered person** utilizes one of the exclusive provider **hospitals** or **outpatient facilities**, the **Plan** will issue a check to the **employee** the amount of the **coinsurance** applied to that **covered expense**.

This benefit is subject to the procedure or **confinement** being a **covered expense** under this **Plan**. This incentive program applies to the **employee** and enrolled **dependents**. The incentive payment shall be issued in the name of the **employee**.

The incentive payment will be issued upon the **claims administrator's** receipt of the claim for the **covered expense**.

The section entitled, *Schedule of Benefits, Preferred Provider Select Hospitals*, shall include the following **providers:**

Desert Ridge Outpatient Surgery Center
20940 N Tatum Blvd #370
PHX 85050
480-502-4010

Metro Surgery Center
6790 W. Thunderbird Rd
Peoria, AZ 85381
623-979-1717

Oasis Hospital
750 N 40th St.
PHX 85008

Canyon Surgery Center
6036 N 19TH Ave #100
PHX 85015

AZ Outpatient Surgery Center
6245 N 16TH St
PHX 85016

The Surgical Hospital of PHX
6501 N 19TH Ave
PHX 85015

Banner Estrella Surgery Center
9301W Thomas Rd
Phoenix, AZ 85037
(623) 388-5700

Phoenix Orthopedic Ambulatory
690 N Cofco Center Ct Ste 150
Phoenix, AZ 85008
(602) 288-4476

Outpatient Surgical Care
1530 W Glendale Ave Ste105
Phoenix, AZ 85021
(602) 995-3395

Peoria Surgery Center
13260 North 94th Drive Suite 200
Peoria, Arizona 85381
Phone: (623) 933-2900

Northwest Tucson Surgery Center AKA Northwest Hospital
(520) 877-6700
6320 N. La Challa Blvd., Suite 100
Tucson, AZ 85741

Oro Valley Hospital
(520) 901-3500
1551E. Tangerine Road
Oro Valley, AZ 85755

Carondelet Foothills Surgery Center
(520) 877-5660
2220 W. Orange Grove Road
Tucson, AZ 85741

US Plan Medical		US Plan BCBS Present Plan		US Plan BCBS Renewal Plan	
Out of Pocket Maximums		In Network	Out of Network	In Network	Out of Network
Individual (In/Out)		\$5,500	\$20,000	\$5,500	\$20,000
Family (In/Out)		\$11,000	\$40,000	\$11,000	\$40,000
Deductible					
Individual (In/Out)		\$750	\$1,500	\$750	\$1,500
Family (In/Out)		\$1,500	\$3,000	\$1,500	\$3,000
Coinsurance					
Office Visit/Specialist		80% + deductible	60% + deductible	80% + deductible	60% + deductible
X-Ray and Lab's		\$15 Copay	60% + deductible	\$15 Copay	60% + deductible
Routine Labs - Primary/Specialist		\$15/\$25 Copay	60% + deductible	\$15/\$25 Copay	60% + deductible
Contracted Provider		80% + deductible	60% + deductible	\$15 Copay	60% + deductible
Hospital and non-Contracted Provider		80% + deductible	60% + deductible	80% + deductible	60% + deductible
Complex Imaging MRI, CT, Pet Scan's etc					
Contracted Provider		80% + deductible	60% + deductible	\$25	60% + deductible
Hospital and non-Contracted Provider		80% + deductible	60% + deductible	80% + deductible	60% + deductible
Rehabilitation 60 Visits		80% + deductible	60% + deductible	\$30 Copay	60% + deductible
combined Physical, Speech, Occupational, Pulmonary, Cardiac, Chiropractic					
Incentive Plan					
Reimbursement Logging - Select Providers		N/A	N/A	Up to \$125 per night up to 4 nights	Not Covered
Hospital and Outpatient - Select Providers		N/A	N/A	100% + deductible	Not Covered
Prescriptions		\$5/\$35/\$55	Not Covered	\$5/\$35/\$55	Not Covered
Mail Order Pharmacy (90 Days)		\$15/\$75/\$135	Not Covered	\$15/\$75/\$135	Not Covered
Emergency Room		80% + deductible	80% + deductible	80% + deductible	80% + deductible
Urgent Care		\$30 Copay	60% + deductible	\$30 Copay	60% + deductible
Hospital		80% + deductible	60% + deductible	80% + deductible	60% + deductible
Out Patient Surgery		80% + deductible	60% + deductible	80% + deductible	60% + deductible
Ambulance		80% + deductible	80% + deductible	80% + deductible	80% + deductible
Behavioral/Mental Health Services					
Inpatient		80% + deductible	60% + deductible	80% + deductible	60% + deductible
Outpatient		\$15 Copay	60% + deductible	\$15 Copay	60% + deductible
Rate Guarantee Period		12 Months		12 Months	
Annual Maximums		Unlimited		Unlimited	
Network		BCBS		BCBS	
Rates:		Four Tier		Four Tier	
Employee	123	\$636.67		\$636.67	
Employee + Spouse	5	\$1,321.22		\$1,321.22	
Employee+ Child	42	\$1,321.22		\$1,321.22	
Family	22	\$2,021.09		\$2,021.09	
Monthly Premium		192	\$184,871.73	\$184,871.73	
Annual Premium			\$2,218,460.76	\$2,218,460.76	
Percentage Change				0.00%	

*Failure to obtain precertification for inpatient hospital, outpatient surgery, non-emergency hospital admissions, and skilled nursing facilities

Incentive Plan reimbursement does not accumulate toward out of pocket or deductible

shall result in a reduction of the plan's coinsurance to 50% for such covered expenses.

*Insured is responsible for balance bill on out-of-network services

Mexico Medical Plan Medical		Mexico Plan Siarmed Present Plan		Mexico Plan Siarmed Renewal Plan	
Out of Pocket Maximums		In Network	Out of Network	In Network	Out of Network
Individual (In/Out)		\$6,250	\$20,000	\$6,250	\$20,000
Family (In/Out)		\$12,500	\$40,000	\$12,500	\$40,000
Deductible					
Individual (In/Out)		\$0	\$0	\$0	\$0
Family (In/Out)		\$0	\$0	\$0	\$0
Coinsurance					
Office Visit/Specialist		100%	50%	100%	50%
Diagnostic Labs		\$5 Copay	50%	\$5 Copay	50%
Contracted Facilities					
Radiology (MRI, MRA, CT, PET)		\$10 Copay	50%	\$10 Copay	50%
Preventative - Lab & Radiology		\$25 Copay	50%	\$25 Copay	50%
		\$5 Copay	50%	\$5 Copay	50%
Prescriptions					
Mail Order Pharmacy (90 Days)		\$3/\$6 Copay	50%	\$3/\$6 Copay	50%
		N/A	N/A	N/A	N/A
Emergency Room		\$250 Copay	\$250 Copay	\$50 Copay	\$50 Copay
Urgent Care		\$20 Copay	50%	\$20 Copay	50%
Hospital		\$50 Copay	50%	\$50 Copay	50%
Out Patient Surgery		\$25 Copay	50%	\$25 Copay	50%
Ambulance		N/A	50%	N/A	50%
Behavioral/Mental Health Services					
Inpatient		Not available	50%	Not available	50%
Outpatient		\$5 Copay	50%	\$5 Copay	50%
Rate Guarantee Period		12 Months		12 Months	
Annual Maximums		Unlimited		Unlimited	
		Siarmed		Siarmed	
Network		Four Tier		Four Tier	
Employee	1	\$232.00		\$232.00	
Employee + Spouse	5	\$481.39		\$481.39	
Employee+ Child	10	\$481.39		\$481.39	
Family	24	\$702.95		\$702.95	
Monthly Premium	40	\$24,323.65		\$24,323.65	
Annual Premium		\$291,883.80		\$291,883.80	
Percentage Change				0.0%	

*Insured is responsible for balance bill on out-of-network services

*Out of Network in Mexico available with Stop Loss carrier approval

*Out of Network will be available in Mexico with approval from the Stop Loss Carrier for Emergency Only

Vision Renewal Rates		Vision Service Plan		Vision Service Plan	
		Current		Renewal;	
		In Network	Out of Network	In Network	Out of Network
Exam Copay		\$10	Up to \$50	\$10	Up to \$50
Frames		\$25	Up to \$70	\$25	Up to \$70
Contact Exam		Up to \$60	N/A	Up to \$60	N/A
Standard Lenses (pair)					
Single		100%	Up to \$50	100%	Up to \$50
Bifocal		100%	Up to \$75	100%	Up to \$75
Trifocal		100%	Up to \$100	100%	Up to \$100
Lenticular		N/A	N/A	N/A	N/A
Progressive (standard)		100%	Up to \$75	100%	Up to \$75
Elective Contact Lenses		Coverage Up to \$130	Up to \$105	Coverage Up to \$130	Up to \$105
Necessary Contact lenses		100%	Up to \$105	100%	Up to \$105
Contact Allowance in lieu of glasses		\$130	Up to \$60	\$130	Up to \$60
LASIK Benefit		Up to 15% Discount	N/A	Up to 15% Discount	N/A
Coverage for Dependents		Up to 26 requires Student Status		Up to 26 requires Student Status	
Frequency					
Exam		12 Months		12 Months	
Lenses		12 Months		12 Months	
Frames		12 Months		12 Months	
Contacts		12 Months		12 Months	
Network		VSP		VSP	
Rate Guarantee				6/30/2023	
RATES:		Two Tier		Two Tier	
Employee Only	143	\$10.70		\$10.91	
Family	96	\$23.00		\$23.46	
Total Monthly Premium	239	\$3,738.10		\$3,812.29	
Annual Premium		\$44,857.20		\$45,747.48	
Percentage Change				1.98%	

*Only one co-pay applies either the materials or the frames, if both services are being received only one co-pay applies.

*Contact lenses are in lieu of glasses
Contracted was negotiated for 4 years

US Mexico and Mexico Dental only Plans

Dental Benefits		US/MX Coverage			Siarmed Mexico Coverage	
		Present	Renewal		Current	Renewal
DEDUCTIBLE					No Out of Network Benefits	No Out of Network Benefits
Individual		\$25	\$25		\$0	\$0
Family		\$50	\$50		\$0	\$0
MAXIMUM ANNUAL BENEFIT						
Orthodontics - Lifetime Max		\$2,000	\$2,000		\$1,000	\$1,000
Orthodontics - Children 19 and under per person		\$2,000	\$2,000		\$1,000	\$1,000
COINSURANCE		50%	50%		50%	50%
Preventive Service						
Basic Services		100%	100%		\$10 Copay	\$10 Copay
Major Services		80%	80%		\$20 Copay	\$20 Copay
Orthodontics		50%	50%		\$50 Copay	\$50 Copay
\$1,000 Lifetime Maximum		50%	50%		50%	50%
RX						
Rate Guarantee		N/A	N/A		N/A	\$3/\$6
RATES:		12 Months	12 Months		12 Months	12 Months
		Four Tier	Four Tier		Four Tier	Four Tier
Employee	127	\$37.60	\$37.60	0	\$16.78	\$16.78
Employee&Spouse	5	\$75.19	\$75.10	9	\$33.55	\$33.55
Employee & Children	28	\$75.19	\$75.19	16	\$33.55	\$33.55
Family	24	\$93.85	\$93.85	29	\$44.73	\$44.73
Total Monthly Premium	184	\$9,508.87	\$9,508.42	54	\$2,135.92	\$2,135.92
Annual Premium		\$114,106.44	\$114,101.04		\$25,631.04	\$25,631.04
Annual Difference			0.00%			0.00%

*Lifetime Maximum - Dependents must be covered under plan for 12 consecutive months before orthodontia is available

*US Dental Coverage allows for coverage in Mexico

***There is no Out of Network coverage on the Mexico Only Plan**

*Deductible applies for Basic, Major and Ortho services in the US

Rx was added to the Mexico plan which is the same as the medical plan

City of San Luis Current / Renewal Basic Life and AD&D - No Change

Benefits	Current and Renewal		
Eligibility	All Employees		
Life Insurance Benefit	1 X Salary to \$50,000		
Basic AD&D	1 X Salary to \$50,000		
Rate Guarantee	6/30/2017		
	Volume	Rates per \$1,000	Monthly Premium
Life Amount		\$0.15	\$1,403.60
AD&D Amount	\$9,357,336	\$0.04	\$374.29
Estimated Annual Premium		\$21,334.73	
Total Change from Current (%)		\$0	
Total Change from Current (\$)		\$0	
Guarantee		2 Year	

Coverage decreases by 35% at age 70 and 50% at age 75

Guarantee is from 7/1/2019 to 6/30/2021

City of San Luis Current / Renewal Long Term Disability - No Change

Benefits		The Standard - CURRENT and Renewal	
Class/ Eligibility		Public Safety Only	
Weekly Benefit		60% of 1st \$16,667	
Maximum Monthly Benefit		\$10,000	
Accident Benefit Begin On Day		181	
Sickness Benefit Begin on Day		181	
Maximum Benefit Period		To age 65	
Employee Assistance Program		Included	
Rate Guarantee			
Volume		Rates per \$100	Monthly Premium
\$214,320		\$0.25	\$535.80
Estimated Annual Premium			\$6,430
Salary			
Total Change from Current (%)		No Change	
Total Change from Current (\$)			
Guarantee		2 year Guarantee	

*Benefit decrease after age 62 or continues to age 65/Social Security age

Guarantee is from 7/1/2019 to 6/30/2021

City of San Luis Current / Renewal Short Term Disability

Benefits	Current and Renewal		Option 1		Option 2	
Eligibility	All Employees		All Employees		All Employees	
Maximum Weekly Benefit	\$2,000		\$2,000		\$2,000	
Accident Benefit Begins on Day	15		15		15	
Sickness Benefit Begins on Day	15		15		15	
Maximum Benefit Duration	180 days		180 days		180 days	
Benefit Percentage	66.67%		66.67%		66.67%	
Off-set Definition	See Below		See Below		See Below	
Rate Guarantee	6/30/2019		6/30/2019		6/30/2019	
Volume	Rates per \$10	Monthly Premium	Rates per \$10	Monthly Premium	Rates per \$10	Monthly Premium
\$116,544	\$0.423	\$4,929.81	\$0.480	\$5,594.11	\$0.580	\$6,759.55
	Annual Premium		Annual Premium		Annual Premium	
	\$59,157.73		\$67,129.34		\$81,114.62	
Total Change from Current (%)	No Change		\$7,971.61		\$21,956.89	
Total Change from Current (\$)			13.48%		37.12%	
Guarantee	2 years		2 years		2 years	

*The STD rate increased from \$0.39 to \$0.423 effective 1/1/2017 to add FICA services to the account
In Second year guarantee

Current plan - No Choice - income offset - all income including sick leave, donated time, other disability, retirement income except vacation

Option plan 1 - Member Choice - can choose either STD Benefits or Sick Leave as benefit, Off-set is other income except vacation

Option plan 2 - Back door Integration - member can take Sick Leave plus STD Benefits up to 100% of income but not more - exception vacation

Transwestern Mexico Voluntary Medical			
Product Description		Current	Renewal
Admin Fee		\$20.25	\$20.50
Broker Fee		\$5.00	\$5.00
Mexico Panel		\$1.00	\$1.00
Hospital Santa Margarita		\$70.00	\$70.00
Total Fixed Costs		\$96.25	\$96.50
Total Monthly Premium	2	\$192.50	\$193.00
Annual Premium		\$385.00	\$386.00
Annual Premium		\$4,620.00	\$4,632.00
Percentage Increase			0.26%
Cobra Rates		\$228.48	\$228.74

City of San Luis
2019-2020 Rates and Contributions

Benefit Type	Coverage	Premium	Employer Cost	Employee Cost	
Which Benefit	Who's Covered	Monthly	Monthly	Monthly	Per Pay Check (24)
<u>Medical</u>– US & Mexico (Mayo/ BCBS)	Employee Only	\$636.67	\$636.67	\$0.00	\$0.00
	Employee & Spouse	\$1,321.22	\$1,021.57	\$299.65	\$149.83
	Employee & Child(ren)	\$1,321.22	\$1,021.57	\$299.65	\$149.83
	Family	\$2,021.09	\$1,562.71	\$458.38	\$229.19
<u>Medical</u>– Mexico Only	Employee Only	\$232.00	\$232.00	\$0.00	\$0.00
	Employee & Spouse	\$481.39	\$372.21	\$109.18	\$54.59
	Employee & Child(ren)	\$481.39	\$372.21	\$109.18	\$54.59
	Family	\$702.95	\$543.52	\$159.43	\$79.71
<u>Dental</u>– US & Mexico	Employee Only	\$37.60	\$37.60	\$0.00	\$0.00
	Employee & Spouse	\$75.19	\$32.87	\$42.32	\$21.16
	Employee & Child(ren)	\$75.19	\$32.87	\$42.32	\$21.16
	Family	\$93.85	\$41.03	\$52.82	\$26.41
<u>Dental</u> – Mexico Only (Siarmed)	Employee Only	\$16.78	\$16.78	\$0.00	\$0.00
	Employee & Spouse	\$33.55	\$14.67	\$18.88	\$9.44
	Employee & Child(ren)	\$33.55	\$14.67	\$18.88	\$9.44
	Family	\$44.73	\$19.55	\$25.18	\$12.59
VSP-Vision Service Plan	Employee Only	\$10.91	\$10.91	\$0.00	\$0.00
	Family	\$23.46	\$10.91	\$12.55	\$6.28
Healthiest You	Employee	\$8.00	\$8.00	\$0.00	\$0.00
	Family	\$0.00	\$0.00	\$0.00	\$0.00
Standard Basic Life & AD&D Insurance	1x Salary up to \$50,000	\$ 0.19 per \$1,000 of annual salary	\$ 0.19 per \$1,000 of annual salary	\$0.00	\$0.00
Standard Short-term Disability	All Employees	\$ 0.423 per \$10 of annual salary	\$ 0.423 per \$10 of annual salary	\$0.00	\$0.00
Standard Long-term Disability	Public Safety Employees	\$0.25 per \$100 of monthly salary	\$0.25 per \$100 of monthly salary	\$0.00	\$0.00
Transwestern Voluntary MX Medical Insurance	Family	\$96.00	\$0.00	\$96.00	\$48.00
Employee Assistance Program	Public Safety Employees	Included with Standard Benefits	\$0.00	\$0.00	\$0.00
EAP Preferred	All Employees	\$2.28	\$2.28	\$0.00	\$0.00

Proposed rates for 7/1/2019 - 6/30/2020

Combined Monthly Total	\$224,652.46	
Employer Contribution Monthly	\$189,109.39	
Other Expenses	\$138,321.59	
Annual Total	\$2,834,151.11	
	Changes from Current:	
	Dollar Change	\$ 29,249.87
	Percent Change	1.03%

EAP Preferred Trust Expense	\$6,402.24
Healthies You Trust Expense	\$23,040
Short Term Disability w/Option 2	\$81,114.62
Long Term Disability	\$6,430.00
Basic Life Insurance	\$21,334.73

23

Current Premium Rates 07-01-2018 to 6-30-2019

Coverage	Enrollment Tier	Medical Rate	Medical Premium	Employer Contribution Medical	Employee Contribution Medical	Dental Rate	Dental Premium	Employer Contribution Dental	Employee Contribution Dental	Vision Rate	Vision Premium	Employer Contribution Vision	Employee Contribution Vision
Medical, Dental & Vision	US & Mexico-Employee Cost	\$ 636.67	\$ 78,310.41	\$ 78,310.41	\$ -	\$ 37.60	\$ 4,775.20	\$ 4,775.20	\$ -	\$ 10.70	\$ 1,530.10	\$ 1,530.10	\$ -
Medical, Dental & Vision	US & Mexico-Spouse Cost	\$ 1,321.22	\$ 6,606.10	\$ 5,107.84	\$ 1,498.26	\$ 75.19	\$ 375.95	\$ 164.37	\$ 211.58				
Medical, Dental & Vision	US & Mexico-Child(ren) Cost	\$ 1,321.22	\$ 55,491.24	\$ 42,905.83	\$ 12,585.41	\$ 75.19	\$ 2,105.32	\$ 920.45	\$ 1,184.87				
Medical, Dental & Vision	US & Mexico-Spouse & Child(ren) Cost	\$ 2,021.09	\$ 44,463.98	\$ 34,379.55	\$ 10,084.43	\$ 93.85	\$ 2,252.40	\$ 984.52	\$ 1,267.88	\$ 23.00	\$ 2,208.00	\$ 1,027.16	\$ 1,180.84
Medical, Dental & Vision	Mexico-Employee	\$ 232.00	\$ 232.00	\$ 232.00	\$ -	\$ 16.78	\$ -	\$ -	\$ -				
Medical, Dental & Vision	Mexico-Employee & Spouse	\$ 481.39	\$ 2,406.95	\$ 1,861.05	\$ 545.90	\$ 33.55	\$ 301.95	\$ 132.04	\$ 169.91				
Medical, Dental & Vision	Mexico-Employee & Children	\$ 481.39	\$ 4,813.90	\$ 3,722.11	\$ 1,091.79	\$ 33.55	\$ 536.80	\$ 234.74	\$ 302.06				
Medical, Dental & Vision	Mexico-Emp, Spouse & Child(ren) Cost	\$ 702.95	\$ 16,870.80	\$ 13,044.50	\$ 3,826.30	\$ 44.73	\$ 1,297.17	\$ 567.25	\$ 729.92				
	Monthly Premium Totals		\$ 209,195.38	\$ 179,563.29	\$ 29,632.09		\$ 11,644.79	\$ 7,778.57	\$ 3,866.22		\$ 3,738.10	\$ 1,738.96	\$ 1,999.14
	Annual Premium Totals		\$ 2,510,344.56	\$ 2,154,759.44	\$ 355,585.12		\$ 139,737.48	\$ 93,342.88	\$ 46,394.60		\$ 44,857.20	\$ 20,867.57	\$ 23,989.63

Combined Monthly Total	\$ 224,578.27
Employer Contribution Monthly	\$ 189,080.82
Other	\$ 109,962.00
Annual Total	\$ 2,804,901.24

Changes from Current:	
Dollar Change	
Percent Change	

Enrollment Counts	Medical	Dental	Healthiest You	Vision
US-Single	123	127	234	143
US-Employee + Spouse	5	5		
US-Employee + Child(ren)	42	28		
US-Family	22	24		96
MX-Single	1	0		
MX-Employee + Spouse	5	9		
MX-Employee + Child(ren)	10	16		
MX-Family	24	29		
	232	238		239

Healthiest You \$8.00 PEPM (240E)	\$23,040
Short Term Disability	\$59,157.73
Long Term Disability	\$6,430.00
Basic Life Insurance	\$21,334.73
Total	\$109,962

2018-2019 Contribution Assumptions				
MEDICAL	EE Only	EE/Spouse	EE/Children	Family
US & Mexico				
Employer %	100.00%	77.32%	77.32%	77.32%
Employee %	0.00%	22.68%	22.68%	22.68%
Mexico				
Employer %	100.00%	77.32%	77.32%	77.32%
Employee %	0.00%	22.68%	22.68%	22.68%
DENTAL	EE Only	EE/Spouse	EE/Children	Family
US & Mexico				
Employer %	100.00%	43.72%	43.72%	43.71%
Employee %	0.00%	56.28%	56.28%	56.29%
Mexico				
Employer %	100.00%	43.73%	43.73%	43.73%
Employee %	0.00%	56.27%	56.27%	56.27%
VISION	EE Only	EE/Spouse	EE/Children	Family
Employer %	100.00%	N/A	N/A	46.52%
Employee %	0.00%	N/A	N/A	53.48%

Contribution Comparison 2018-2019 - 2019 - 2020

Contribution Changes Employee Benefits - Employer (ER), Employee (EE)

	Current Plan			Renewal Option				
	2018-2019 Total Premium	2018-2019 ER Contribution	2018-2019 EE Contribution	2019-2020 Total Premium	2019-2020 ER Contribution	2019-2020 EE Contribution	ER Difference Contribution	% Change
Medical (US & Mex)	\$ 2,510,344.56	\$ 2,154,759.44	\$ 355,585.12	\$ 2,510,344.56	\$ 2,154,688.09	\$ 355,656.47	\$ (71.35)	0.00%
Dental (US & Mex)	\$ 139,737.48	\$ 93,342.88	\$ 46,394.60	\$ 139,737.48	\$ 93,342.88	\$ 46,394.60	\$ -	0.00%
Vision	\$ 44,857.20	\$ 20,867.57	\$ 23,989.63	\$ 45,747.48	\$ 21,281.73	\$ 24,465.75	\$ 414.16	1.98%
Short Term Disability	\$59,157.73	\$ 59,157.73	\$ -	\$81,114.62	\$ 81,114.62	\$ -	\$ 21,956.89	37.12%
Long Term Disability	\$6,430.00	\$ 6,430.00	\$ -	\$6,430.00	\$ 6,430.00	\$ -	\$ -	0.00%
Basic Life	\$21,334.73	\$ 21,334.73	\$ -	\$21,334.73	\$ 21,334.73	\$ -	\$ -	0.00%
Transwestern (Not Included in Budget)	\$ 2,310.00	\$ -		\$2,316	\$ -			0.00%
Total Budget Requirements	\$ 2,784,171.70	\$ 2,355,892.34	\$ 425,969.36	\$ 2,807,024.87	\$ 2,378,192.05	\$ 426,516.82	\$ 22,299.70	0.94%

Premium Increases	\$	%
Medical Premium (US & Mexico)	\$0.00	0.00%
Dental Premium	\$0.00	0.00%
Life, STD, LTD Premium	\$21,956.89	25.26%

Summary

Medical	Increase in Total Premium	\$0.00
	Employer Portion	-\$71.35
	Employee Portion	\$71.35
Dental	Increase in Total Premium	\$0.00
	Employer Portion	\$0.00
	Employee Portion	\$0.00
Total Changes:	All Benefits	\$22,853.17
	ER	\$22,299.70
	EE	\$547.47

**City of San Luis
EMPLOYEE BENEFIT TRUST**

**SUMMARY PLAN DESCRIPTION AND
PLAN DOCUMENT**

EBSO GROUP NUMBER: SLS001

Effective: July 1, 2018

TABLE OF CONTENTS

SECTION A	2
INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION	2
<i>Introduction and Purpose</i>	2
<i>General Plan Information</i>	3
SECTION B	5
SCHEDULE OF COVERAGE	5
SECTION C	10
DEFINITIONS OF GENERAL TERMS	10
SECTION D	30
ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE	30
EMPLOYEE ELIGIBILITY DATE	30
EMPLOYEE EFFECTIVE DATE OF COVERAGE	30
DEPENDENT ELIGIBILITY DATE	30
DEPENDENT EFFECTIVE DATE OF COVERAGE	31
CHANGE IN STATUS	31
SPECIAL ENROLLMENT PERIOD	32
OPEN ENROLLMENT PERIOD	33
CHOOSING PLAN OPTIONS	34
TERMINATION OF INDIVIDUAL COVERAGE	34
SECTION E	37
CONTINUATION OF COVERAGE UPON INDIVIDUAL TERMINATION (COBRA)	37
SECTION F	49
UNIFORMED SERVICES CONTINUATION AND REINSTATEMENT PROVISION	49
SECTION G	51
GENERAL LIMITATIONS AND EXCLUSIONS	51
SECTION H	62
PRE-CERTIFICATION	62
SECTION I	63
COMPREHENSIVE MAJOR MEDICAL BENEFITS	63
COVERED EXPENSES	63
SECTION J	85
DEDUCTIBLE PROVISIONS	85
ANNUAL OUT-OF-POCKET MAXIMUM BENEFIT	85
SECTION K	86
PPO OPTION	86
<i>Responsibility for use of Preferred Providers</i>	86
<i>Continuity of Care</i>	87
SECTION L	88
PRESCRIPTION DRUG CARD BENEFIT	88

SECTION M	89
CARE PROVIDED BY THE UNITED STATES GOVERNMENT	89
COORDINATION OF BENEFITS	89
EFFECT ON BENEFITS	90
SECTION N	94
MEDICARE SELECTION PROVISION	94
SECTION O	95
GENERAL PROVISIONS	95
<i>The Plan and The Master Plan Document</i>	95
<i>Plan Administrator</i>	95
<i>Named Fiduciary</i>	95
<i>Claims Administrator</i>	95
<i>The Plan Is Not An Employment Contract</i>	96
<i>Exchange Of Information</i>	96
<i>Alternative Treatment</i>	96
<i>Free Choice of Physician</i>	97
<i>Qualified Medical Child Support Orders (QMCSO)</i>	97
<i>Other Service Plan Contracts</i>	98
<i>Worker's Compensation Notice</i>	98
<i>Erroneous Payment Refund Provision</i>	98
<i>Conformity With Applicable Law</i>	99
<i>Clerical Error</i>	99
<i>Fraud</i>	99
<i>No Waiver</i>	100
<i>Plan Contributions</i>	100
<i>Plan Modification and Amendment</i>	101
<i>Automatic Assignment</i>	101
<i>Physical Examination</i>	102
<i>Disclosure Of Electronic Protected Health Information ("Electronic PHI") To The Plan Sponsor For</i>	
<i>Plan Administration Functions</i>	102
<i>Privacy Standards</i>	102
SECTION P	106
SUBROGATION/RIGHT OF REIMBURSEMENT	106
SECTION Q	113
CLAIM/APPEAL PROCEDURES	113

ESTABLISHMENT OF THE MASTER PLAN DOCUMENT

Effective July 1, 2018, the Plan Sponsor establishes City of San Luis Employee Benefit Plan (the "Plan") to provide self-funded benefits for its Employees and their Dependents.

This Plan replaces the Plan Sponsor's previous plan of medical and prescription drug card benefits. It is the intent of the Plan Sponsor to provide continuous eligibility and coverage from the previous plan to this Plan.

The Plan Sponsor hereby adopts this Plan Document as the written description of the Plan.

Disclaimer Of Claims Administrator

EBSO, Inc. has prepared this document for your review and consideration; however, we are not legal counsel, nor are we in the business of practicing law. As your Plan's fiduciary, you are fully responsible for all legal issues that concern the Plan. If you are not an expert in this area, we urge you to hire an attorney to help you review this Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Date

Signature

Print or Type Name and Title

Witness Signature

Print or Type Witness Name

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Medical and surgical benefits to women who have undergone a mastectomy (a surgical procedure to remove the breast or breast tissue) were expanded under the federal Women's Health and Cancer Rights Act in 1998. The bill has a provision that requires health plans to provide coverage for certain mastectomy related procedures. As a Plan Member, you receive coverage for all stages of reconstruction of the breast on which the mastectomy was performed, breast prosthesis (artificial substitute), and physical complications of mastectomy including lymphedemas, surgery, and reconstruction of the other breast to produce a symmetrical appearance. Treatments are subject to the same Copays and Deductibles (where applicable) as other covered surgical procedures. For more information on Copays and Deductibles for surgical procedures, see the Schedule of Coverage.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

SECTION A

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

City of San Luis, the Employer, has established the City of San Luis Employee Benefit Trust in order to provide comprehensive healthcare benefits for Employees, and their Dependents.

The City of San Luis Employee Benefit Trust is a self-insured public sector plan within the meaning of Arizona Statute 11-981 (hereinafter "Plan"). The Plan is not an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). Any resemblance to an ERISA plan shall not be construed to mean it is an ERISA plan. The Plan is a self-insured medical plan intended to meet the requirements under Sections 105(b), 105(h) and 106 of the Internal Revenue Code of 1986 so the portion of the cost for coverage paid by the Employer is not taxable income to the Employee and any benefits received through the Plan are not taxable income to the Employee. This Plan is a group health plan for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and shall be administered in a manner consistent with HIPAA.

The Plan Sponsor has established the Plan for the benefit of eligible employees and their eligible dependents, on the terms and conditions described herein. The Plan Sponsor's purpose in establishing the Plan is to help to offset, for eligible Employees, the economic effects arising from a non-occupational Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

This Plan is a non-grandfathered plan under Patient Protection and Affordable Care Act (PPACA) and Health Care and Education Reconciliation Act (HCERA), collectively referred to as Health Care Reform.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain medical expenses. The Plan Document is maintained by the Plan Sponsor and may be inspected at any time during normal working hours by any Plan Member.

The Schedule of Coverage is meant only as a summary of benefits. For more details about the benefits, check the Table of Contents and refer to the specific section in the booklet for complete terms and conditions.

This Plan covers only those expenses incurred in connection with non-occupational injuries or disease.

The Employer has contracted with the Claims Administrator to perform certain consultative and management services related to the Plan. The Employer retains ultimate authority for the Plan.

Certain words in this Plan have precise meanings and will be capitalized and defined in the Definition section or where used in the text, so that you will pay special attention to them.

New Rescission of Coverage Rules. Under this Plan, coverage may be retroactively cancelled or terminated if you act fraudulently or make material misrepresentations of fact. It is your responsibility to provide accurate information and to make accurate and truthful statements including information and statements regarding familial status, age, relationships, etc. In addition, it is your responsibility to update previously provided information and statements. Failure to do so may result in your coverage, including the coverage of those provided coverage through you, being cancelled and such cancellation may be retroactive.

General Plan Information

Name of Plan:	City of San Luis Employee Benefit Trust
Plan Sponsor:	City of San Luis 1090 E. Union Street San Luis, AZ 85349 928-341-8547
Plan Administrator: (Named Fiduciary)	City of San Luis 1090 E. Union Street San Luis, AZ 85349 928-341-8547
Plan Sponsor ID No. (EIN):	86-0376164
Fiscal Year:	January 1 through December
Plan Number:	501
EBSO Group Number:	SLS001
Type of Administration:	Self-funded Welfare Plan Prescription Drug Plan

Sources and Methods of
Contributions to the Plan:

The Employer and the Employee share in the cost of the Plan. The Employer's contribution is made from his general assets and the Employee's contribution is made from payroll deductions. The Employer will provide a schedule of the applicable premiums during the initial enrollment, during open enrollment periods, on the Plan's annual renewal date and upon request.

All contributions shall be held in the Trust.

The Plan is "self-insured" which means that benefits are paid with assets from the Trust established by the Employer to pay benefits under the Plan.

Name of Trust

City of San Luis Employee Benefit Trust

Trustees

For current information on Trustees, please refer to the Agreement and Declaration of Trust for City of San Luis Employee Benefit Trust

Claims Administrator:

EBSO, Inc.
215 Stanford Pkwy
Findlay, OH 45840
Phone Number 800-558-7798

Please Note: EBSO, Inc. performs claims processing services pursuant to a contract, it does not insure benefits under the Plan.

Agent for Legal Services:

City of San Luis
1090 E. Union Street
San Luis, AZ 85349
928-341-8547

This document is the Summary Benefit Description (SBD) that describes the basic features of the Plan and how the plan operates.

It is very important to review this document carefully to confirm a complete understanding of the benefits available, as well as responsibilities, under the Plan. The SBD should be read in its entirety because many of its provisions are interrelated.

SECTION B SCHEDULE OF COVERAGE

NOTE: THIS IS ONLY A SUMMARY, SPECIFIC SERVICES AND SUPPLIES MAY BE SUBJECT TO OTHER DEDUCTIBLES, COPAYS, PAYMENT PERCENTAGES, MAXIMUM BENEFIT PAYMENTS, AND/OR EXCLUSIONS AND LIMITATIONS.

NOTE: Benefits under this Plan will be paid only if the Plan Administrator decides in his/her discretion that the individual is entitled to them.

COMPREHENSIVE MAJOR MEDICAL PLAN:

DEDUCTIBLE PER COVERAGE YEAR

PPO: \$750 INDIVIDUAL
\$1,500 FAMILY

NON-PPO: \$1,500 INDIVIDUAL
\$3,000 FAMILY

The PPO Deductible and the Non-PPO Deductible shall accumulate independently and shall not be used to satisfy each other.

The family Deductible is the amount contributed toward the Deductible by two or more family members; provided, the amount contributed toward the family Deductible by any one family member cannot be more than the individual Deductible amount.

ANNUAL OUT-OF-POCKET MAXIMUM PER COVERAGE YEAR

PPO: \$5,500 INDIVIDUAL
\$11,000 FAMILY

NON-PPO: \$20,000 INDIVIDUAL
\$40,000 FAMILY

The PPO Annual Out-of-pocket Maximum and the Non-PPO Annual Out-of-pocket Maximum shall accumulate independently and shall not be used to satisfy each other.

The family Annual Out-of-pocket is the amount contributed toward the Annual Out-of-pocket by two or more family members; provided, the amount contributed toward the family Annual Out-of-pocket by any one family member cannot be more than the individual Annual Out-of-pocket amount.

The Annual Out-of-pocket Maximum **includes** the Deductible, Coinsurance, and Copays. The Annual Out-of-pocket Maximum does **NOT** include any charge in excess of the established plan maximums/limitations and penalties for non-compliance with Plan provisions.

COVERAGE YEAR MAXIMUM PAYMENT AMOUNT	Unlimited

PRE-CERTIFICATION IS REQUIRED FOR THE FOLLOWING SERVICES:

- All non-Emergency Hospitalizations (including skilled nursing facility, inpatient rehabilitation and residential treatment facilities)
- Outpatient surgery
- Special Services, such as acupuncture, podiatry and TMJ
- CT Scans, Pet Scans and MRIs
- Hospice
- Home Health Care
- Durable Medical Equipment > \$750 or when rental exceeds 4 months
- Inpatient Rehabilitation/Habilitation services

FOR PRE-CERTIFICATION CALL EBSO-REVIEW, AT 1-800-426-9317. Non-compliance reduces benefits. If a Plan Member does not comply with Pre-certification when required, Covered Expenses

will be reduced by a penalty of
PPO: \$500 per service or
Non-PPO: 50% of the total cost of the service.
This reduction is in addition to the Deductible.

THE PPO IS ADMINISTERED BY: **BCBS of Arizona**
Multiplan wrap
In Mexico, SIARMED

The Plan will at all times be in compliance with PPACA rules and regulations. PPACA requires that benefits that are offered by the Plan that are “Essential Health Benefits” as defined by the United States Department of Health And Human Services may not be restricted to less than a certain annual amount. If a major medical benefit of the Plan has a plan maximum below that amount, the Plan will continue to pay benefits for the Essential Health Benefit components of that benefit even though such payments would exceed the plan maximum for that benefit, but only until the Coverage Year Maximum Payment Amount of the Plan is paid.

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Acupuncture	80% after Deductible	60% after Deductible	LIMITED to a maximum of 26 visits per Coverage Year.
Ambulance Services -Air and Ground	80% after Deductible	80% after Deductible	
Amino acid-based formula	25% after Deductible	25% after Deductible	LIMITED to supplies not covered under the Prescription Drug Card Benefit. The maximum annual benefit for amino acid based formula to treat eosinophilic gastrointestinal disorder is \$20,000 per Plan Member per Coverage Year.
Chiropractic Care	100% after a \$15 Copay per visit (Deductible waived)	60% after Deductible	Includes x-rays, manipulations, supportive care, and maintenance care. LIMITED to a maximum of 20 visits per Coverage Year.
Dental Hospitalization and Dental Services Office Visits	80% after Deductible	60% after Deductible	Diagnostic procedures & treatment of TMJ are LIMITED to a Lifetime maximum benefit payment of \$300.
Durable Medical Equipment, Prosthetics, Orthotics and Disposable Supplies	80% after Deductible	60% after Deductible	Hearing aids are LIMITED to one per Coverage Year.
Emergency Services and Urgent Care Services			In an Emergency, as defined by the Plan, Non-PPO Covered Expenses will be paid at the PPO level.
Emergency visit	80% (Deductible waived).	80% (Deductible waived).	
Urgent Care	100% after a \$30 Copay per visit (Deductible waived)	60% after Deductible	

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Home Health Care	80% after Deductible	60% after Deductible	LIMITED to a maximum of 60 visits per Coverage Year.
Hospice Care	80% after Deductible	60% after Deductible	Bereavement Counseling is LIMITED to a Lifetime maximum benefit payment of \$300 per family.
Inpatient Hospital Services (Non-Emergency), Outpatient Hospital, or Ambulatory Surgical Center Services	80% after Deductible	60% after Deductible	
Inpatient and Outpatient Physician Services			
Primary Care Physician Office Visits (includes lab and X-ray)	100% after a \$15 Copay per visit (Deductible waived)	60% after Deductible	
Specialist Office Visits (includes lab and X-ray)	100% after a \$25 Copay per visit (Deductible waived)	60% after Deductible	
Inpatient Visit	100% after a \$15 Copay per visit (Deductible waived)	60% after Deductible	
Surgery (Physician's office)	100% after a \$15 Copay per visit (Deductible waived)	60% after Deductible	
Surgery (other)	80% after Deductible	60% after Deductible	
Physician Services – Pathology, Anesthesiology, or Radiology	80% after Deductible	60% after Deductible	
Maternity			
Prenatal visits	100% (Deductible and Copays waived)	60% after Deductible	
Hospital Services	80% after Deductible	60% after Deductible	

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Medical Foods	50% after Deductible	Not covered except in an Emergency. In an Emergency, covered expenses will be paid at PPO level.	LIMITED to supplies not covered under the Prescription Drug Card Benefit. The maximum annual benefit for medical food to treat an Inherited Metabolic Disorder is \$5,000 per Plan Member per Coverage Year.
Mental/Nervous Disorders and/or Substance Abuse			
Inpatient treatment	80% after Deductible	60% after Deductible	
Outpatient treatment	100% after a \$15 Copay per visit (Deductible waived)	60% after Deductible	
Outpatient Diagnostic Tests			
Complex - MRI, CT, PET Scans	80% after Deductible	60% after Deductible	
Other X-rays and Laboratory tests – primary care	100% after a \$15 Copay per visit (Deductible waived)	60% after Deductible	
Other X-rays and Laboratory tests – Specialist care	100% after a \$25 Copay per visit (Deductible waived)	60% after Deductible	
Preventive Care Services			Refer to benefit section for more information on Preventive Services. Includes prescription contraceptives, unless covered under the Prescription Drug Card Benefit. Cost sharing will apply to a brand name contraceptive if a generic version is available and just as effective and safe.
Pediatric and Adult Preventive Care	100% (Deductible waived)	80% after Deductible	
Immunizations, inoculations, vaccinations	100% (Deductible waived)	100% after a \$20 Copay per visit (Deductible waived)	
Sterilization – limited to Employee and covered Spouse only	100% (Deductible waived)	80% after Deductible	

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Rehabilitation and Habilitation Services			Physical, Occupational and Speech therapy are LIMITED to a maximum of 60 Outpatient visits per Coverage Year, combined.
Physical, Speech, Occupational Therapy	100% after a \$30 Copay per visit (Deductible waived)	60% after Deductible	
All Other	80% after Deductible	60% after Deductible	
Skilled Nursing Facility	80% after Deductible	60% after Deductible	LIMITED to a maximum of 90 days per Coverage Year.
Therapy services – Chemotherapy, Dialysis, Radiology	80% after Deductible	60% after Deductible	
Transplants			
Hospitalization	80% after Deductible	60% after Deductible	
Associated Office Visits	100% after a \$15 Copay per visit (Deductible waived)	60% after Deductible	
All other Covered Expenses	80% after Deductible	60% after Deductible	

PRESCRIPTION DRUG CARD EXPENSE BENEFIT

NOTE: Copays may not apply to certain preventive prescription and over-the-counter medications. Contact the Prescription Drug Card Administrator for more information. Note: the brand name copay will apply to a brand name contraceptive if a generic version is available and just as effective and safe.

Prescriptions must be obtained through Magellan Rx, except in an emergency. Prior authorization is required for some prescription drugs.

Retail (30 day supply)

Formulary Generic/Diabetes syringes or lancets	\$5 Copay
Formulary Brand	\$35 Copay
Non-Formulary Brand	\$55 Copay
Diabetic insulin (2 vials) or test strips	\$25 Copay

Magellan Rx Mail Service Program (90 day supply)

Formulary Generic/Diabetes syringes or lancets	\$15 Copay
Formulary Brand	\$75 Copay
Non-Formulary Brand	\$135 Copay
Diabetic insulin (6 vials) or test strips	\$75 Copay

THE PRESCRIPTION DRUG CARD EXPENSE BENEFIT IS ADMINISTERED BY: Magellan Rx

SECTION C

DEFINITIONS OF GENERAL TERMS

When used and capitalized in this document, these terms have the following definitions. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of the Plan Document for that information.**

ALLOWED CHARGE means the maximum dollar amount eligible for payment for a procedure or service as determined by the Plan. This includes billed charges, contracted amounts or Usual, Customary and Responsible Fees, depending on the healthcare provider's relationship with the Plan and/or the healthcare services provided.

AMBULATORY SURGICAL CENTER means a facility with an organized staff of Physicians which:

1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
2. Provides treatment by and under the supervision of Physicians and nursing services when the patient is in the facility;
3. Does not provide Inpatient accommodations;
4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician.

ANNUAL OUT-OF-POCKET MAXIMUM means the total Coinsurance, Deductible and Copay amounts for certain Covered Services that are a Plan Member's responsibility during a Coverage Year. The following amounts are *not* considered or taken into account: charges that are not Covered Services under the Plan (e.g., charges which exceed Usual, Customary and Reasonable Fee and costs paid by the Plan Member as a result of a failure to comply with Prior Authorization requirements), and charges in excess of Plan maximums. When the Annual Out-of-Pocket Maximum is met, the Plan will pay 100% of the Allowed Charge for certain Covered Services incurred during the remainder of the Coverage Year. The Annual Out-of-Pocket Maximum renews on the Plan anniversary of each consecutive Coverage Year.

BIRTHING CENTER means a facility operating as part of a Hospital, or as a free-standing facility solely engaged in providing an alternative to conventional obstetrics which:

1. Is licensed as such and is operating within the scope of its license; and
2. Is directed by a Physician specializing in obstetrics or gynecology; and
3. Has a Physician or certified nurse mid-wife, present at all births and during the immediate post-partum; and
4. Is equipped and has a trained staff, or has a written agreement with the Hospital to handle emergencies including the transfer of a patient or child; and
5. Maintains medical records on each patient and provides an ongoing quality assurance program.

CALENDAR YEAR means the period from January 1 through the following December 31.

CONFINEMENT means a continuous stay in the Hospital(s) or extended care facility(ies) or combination thereof, due to a Sickness or Injury diagnosed by a Physician, which lasts at least one day and one night.

COPAY means an amount payable by the Plan Member before benefits are payable by the Plan. In some instances, the Plan Member will be responsible at the time and place of service to pay any Copay directly to the healthcare provider. In other instances, the Plan Member will be billed by the healthcare provider. These arrangements are between the Plan Member and the healthcare provider. Copays do not count toward the Deductible.

COINSURANCE means the charge a Plan Member must pay for certain Covered Services after any applicable Deductibles and Copays have been paid and until the Annual Out-of-Pocket Maximum has been reached. Covered Services subject to Coinsurance and the amounts are listed in the Schedule of Coverage. Coinsurance is a percentage of the Allowed Charge. In some instances, the Plan Member will be responsible at the time and place of service to pay any Coinsurance directly to the healthcare provider. In other instances, the Plan Member will be billed by the healthcare provider. These arrangements are between the Plan Member and the healthcare provider.

COSMETIC PROCEDURE means a procedure performed solely for the improvement of a Plan Member's appearance rather than for the improvement or restoration of bodily function. Breast reconstruction or a breast prosthesis following a mastectomy is **NOT** considered a Cosmetic Procedure.

COVERAGE YEAR means when services are covered under this Plan. This means that benefit maximums, Deductibles and Coinsurance limits start and stop during this time. The Plan's Coverage Year is January 1 – December 31.

COVERED SERVICE means healthcare services described in the Plan for which benefits will be provided, unless limited or excluded in the Plan. A Covered Service is Incurred on the date the healthcare service is received.

COVERED EXPENSES are charges for services that are covered under the Plan. Some charges, although eligible, may be subject to Deductible, Copay and Coinsurance provisions where applicable and, therefore, are the Plan Member's responsibility to pay. Charges for non-covered expenses are also the Plan Member's responsibility.

CREDITABLE COVERAGE means the period of time that an individual has been covered by any of the following medical programs:

1. This Plan;
2. Another group health plan;
3. Non-group or individual health insurance coverage issued by a state regulated insurer (including Blue Cross type plans) or an HMO;
4. Medicare (Part A or Part B);
5. Medicaid;
6. Title 10 U.S.C. Chapter 55;
7. American Indian Health Care Programs;
8. A state health benefits risk pool;
9. The Federal Employees Health Plan;
10. A "public health plan" including any plans established or maintained by a state, the U.S. government, a foreign country, or any political subdivision

of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;

11. The Peace Corp Health Program;
12. A State Children's Health Insurance Program (S-CHIP).

CUSTODIAL CARE means the type of care that is designed chiefly to help a person meet activities of daily living. It does not entail or need the continuing attention of trained medical personnel such as registered nurses and licensed practical nurses. Custodial Care includes services which make up personal care such as help in walking and getting in and out of bed; help in bathing, dressing, feeding, and using the toilet; preparation of special diets; and supervision of medication which usually can be self-administered. Care may still be custodial even though it involves the use of technical medical skills if those skills can be easily taught to a lay person.

DAY HOSPITALIZATION means the continuous treatment of a Mental/Nervous Disorders and/or Substance Abuse at a Hospital, intermediate care facility or other covered facility for not less than five hours and not more than eighteen hours in any 24-hour period. It does not include an Inpatient stay in the Hospital.

DEDUCTIBLE means the amount of Covered Expenses payable by the Plan Member each Calendar Year before benefits are paid by the Plan.

DENTIST means a duly licensed Dentist or Physician who is acting within the scope of his/her license.

DEPENDENT includes only an Employee's:

1. Spouse (Spouse means an individual as recognized as a spouse for purposes of federal tax laws, including the Code. A Spouse who is legally separated or divorced from the Employee is specifically excluded from the definition of Spouse); and
2. Unmarried or married children who are less than 26 years of age;
3. Unmarried children age 26 or older who are incapable of self-sustaining employment because of a developmental disability or physical disability and are chiefly dependent upon the Employee for support and maintenance. Proof of such incapacity must be furnished within 31 days of the children reaching the limiting age and annually thereafter.

"Developmental disability" means substantial handicap which results from mental retardation, cerebral palsy, or other neurological disorder.

"Physical disability" means a physical impairment that substantially limits one or more major life activities such as hearing; breathing; mobility (ability to move); learning; or receptive (understanding) and expressive language. Physical disabilities include but are not limited to: blindness/visual impairment; cancer; diabetes; head injury; heart disease; and mobility impairments. An individual with a minor, non-chronic condition of short duration, such as a sprain, broken limb, or the flu, is not considered disabled.

4. Child for whom coverage is required by a Qualified Medical Child Support Order or by an administrative process established under state law.

The term children includes the following:

1. A biological child;
2. An adopted child, including a child placed for adoption. Placement for adoption occurs when an Employee, in anticipation of adopting a child, assumes and retains legal obligation for the total or partial support of that child. Adoptive placement ceases when or if legal obligation ceases;
3. A stepchild;
4. a child for whom the Employee and/or the Employee's Spouse has been named legal guardian, or
5. A child for whom the Employee is legally financially responsible.
6. A foster child.

At any time, the Plan may require proof that a spouse or child qualifies or continues to qualify as a Dependent as defined by the Plan.

Individuals specifically excluded from the definition of a Dependent are:

1. any person on active military duty;
2. the grandchild of an Employee and/ or the Employee's Spouse;
3. any person covered under this Plan as an Employee; and
4. any person covered as a Dependent by another Employee.

DIAGNOSTIC means a test or procedure performed because the Plan Member has specific symptoms or which is required to detect or monitor a certain condition or disease. Such test or procedure must be ordered by a Physician or Health Care Professional, and it must be related to the Plan Member's symptoms.

DURABLE MEDICAL EQUIPMENT means equipment which is prescribed by a Physician and is primarily and customarily used to serve a medical purpose, able to withstand repeated use, and not generally useful to a person in the absence of an Injury or Sickness.

EBSO means EBSO, Inc.

EFFECTIVE DATE means the date on which a person's coverage under this Plan begins.

EMERGENCY/EMERGENCY CONDITION means a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;
2. Serious impairment to such person's bodily functions;
3. Serious dysfunction of any bodily organ or part of such person; or
4. Serious disfigurement of such person.

EMERGENCY SERVICES means with respect to an Emergency Condition:

1. a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

2. such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as required to stabilize the patient.

EMPLOYEE means an Employee of the Employer who is regularly scheduled to actively perform the principle duties of his/her occupation a minimum of 30 hours per week, and who is enrolled and eligible for coverage under the Plan.

Part-time, seasonal, temporary and retired employees are not eligible for coverage under the Plan. Employee does not include the following:

1. a self-employed individual as described in Section 401 (c) of the Code, including, but not limited to, a sole proprietor if the Employer is a sole proprietorship, a person owning more than 2% of the Employer if it is a Subchapter S corporation, a partner of the Employer if it is a partnership, and a member of the Employer if it is a limited liability company and the members are treated as partners for income tax purposes;
2. an employee who is a spouse, child, grandchild, or parent of a person owning more than 2% of the Employer if it is a Subchapter S corporation;
3. any individual included within a unit of employees covered by a collective bargaining unit unless such agreement expressly provides for coverage of the Employee under the Plan;
4. any individual who is a nonresident alien and receives no earned income from the Employer from sources within the United States;
5. any individual who is a leased employee as defined in Section 414(n)(2) of the Code;
6. any individual who performs services for the Employer through, and is paid by, a third-party (including but not limited to an employee leasing or staffing agency) even if such individual is subsequently determined to be a common law employee of the Employer; or
7. any individual who performs services for the Employer pursuant to a contract or agreement (whether verbal or written) which provides that such individual is an independent contractor or consultant, even if such individual is subsequently determined to be a common law employee of the Employer.

EMPLOYER means City of San Luis.

ESSENTIAL HEALTH BENEFITS means:

1. Ambulatory patient services;
2. Emergency services;

3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

EXPERIMENTAL/INVESTIGATIONAL/INVESTIGATIVE means a drug, device, medical treatment or procedure that meets any of the following:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. The drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or
3. Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

For purposes of this definition, Reliable Evidence means published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

HEALTH CARE PROFESSIONAL means a licensed health care practitioner, other than a Physician (as defined by this Plan), who is legally licensed or certified and, within the scope of that license or certificate, is permitted to perform the services for which benefits are provided under this Plan. The term "Health Care Professional" includes, but is not limited to: a registered dietician, nurse midwife, audiologist, Physician's assistant, psychologist, nurse anesthetist, certified nurse practitioner, physical therapist, occupational therapist, speech therapist, speech pathologist, DME provider, License Practical Nurse (L.P.N.), Advanced Practice Registered Nurse, Radiation Therapist, Registered Nurse (R.N.), respiratory therapist, social worker, and an operating room technician (only when an assistant surgeon is not present). The Health Care Professional may be an independent Health Care Professional, however, his/her services must be recommended and approved by the Plan Member's attending Physician. The Health Care Professional may not be a member of the Plan Member's Immediate Family or a person who normally resides with the Plan Member.

HOME HEALTH CARE means care and treatment of a Plan Member provided by or coordinated through:

1. A Home Health Care Agency; or
2. A certified rehabilitation agency.

The care and treatment must be included in a Plan of Home Health Care approved in writing by the attending Physician. The Plan of Home Health Care must be revised every two months unless the attending Physician indicates in writing that a longer review period is sufficient. If the Plan Member was Hospital confined immediately prior to requiring home care, the Plan of Home Health Care must be approved by the Physician who was the primary provider of services during the confinement.

HOME HEALTH CARE AGENCY means a home health agency or a visiting nurses' association which meets all of the following requirements:

1. Is licensed by the state;
2. Qualifies as a Home Health Care Agency under Medicare;

3. Meets the standards of the applicable area-wide health care planning agency;
4. Provides skilled nursing services and other services on a visiting basis in the patient's home;
5. Is responsible for administering a Plan of Home Health Care; and
6. Supervises the delivery of a Plan of Home Health Care as prescribed and approved in writing by the patient's attending Physician.

HOME HEALTH CARE SERVICES means nursing services; dietary advice; social service guidance; physical, occupational, speech or respiratory therapy; laboratory services; drugs; dressings and medical supplies; and related services under the direction of a licensed Physician or surgeon provided in the place of and as an extension of care in a Hospital.

HOSPICE AGENCY means a public agency or private organization which meets all of the following requirements:

1. Is primarily engaged in providing care to Terminally Ill patients;
2. Provides 24-hour care to control the symptoms associated with Terminal Illness;
3. Has on its staff an interdisciplinary team which includes at least one Physician, one registered professional nurse (R.N.), one social worker, and at least one pastoral or other counselor, and volunteers;
4. Must be a licensed organization whose standards of care meet those of the National Hospice Organization;
5. Maintains central clinical records on all patients;
6. Provides appropriate methods of dispensing drugs and medicines; and
7. Offers a coordinated program of home care and Inpatient care for a Terminally Ill patient.

The term "Hospice" does **NOT** include an organization or part thereof which:

1. Is primarily engaged in providing:

- a. Custodial Care;
 - b. Care for Substance Abusers; or
 - c. Domestic services;
- 2. Is a place of rest;
- 3. Is a place for the aged; or
- 4. Is a hotel or similar institution.

HOSPITAL means a place that meets all of the following requirements:

- 1. It is accredited as a general Hospital by the Joint Commission on Accreditation of Hospitals;
- 2. It is open at all times;
- 3. It is operated chiefly for the treatment of sick or injured persons as Inpatients;
- 4. It has a staff of one or more Physicians available at all time;
- 5. It provides 24-hour nursing service by graduate registered nurses; and
- 6. It includes areas designed for diagnosis and major surgical procedures. Or, if it is chiefly a place for the treatment of mentally handicapped persons, it has an agreement, by contract or otherwise, with an accredited Hospital to perform Surgery which may be required.

The term "Hospital" does **NOT** include: a convalescent, nursing, rest, or Skilled Nursing Facility.

HOSPITAL MISCELLANEOUS EXPENSES means the actual charges made by a Hospital, other than room and board, on its own behalf for services and supplies rendered to the Plan Member, on an Inpatient or Outpatient basis, which are Medically Necessary for the treatment of such Plan Member. This includes Hospital admission kits, but all other personal or convenience items are excluded.

IMMEDIATE FAMILY means the Plan Member's spouse, children, brothers, sisters, grandparents, or the parents of the Plan Member or his/her spouse.

INCURRED means the day and time of day Covered Expenses are provided. It does not include a date on which a Plan Member contracts for future delivery of supplies or services.

INHERITED METABOLIC DISORDERS means an inherited disorder: (1) specified in the newborn screening program prescribed by Arizona law, including phenylketonuria (PKU), maple sugar urine disease, homocystinuria, and galactosemia; (2) involving amino acid, carbohydrate, or fat metabolism; (3) having medically standard methods of diagnosis, treatment, and monitoring including quantification of metabolites in blood, urine, or spinal fluid or enzyme or DNA confirmation in tissues; and (4) requiring specially processed or treated medical foods: (i) that are generally available only under the supervision and direction of a Physician, (ii) that must be consumed throughout life, and (iii) without which the Plan Member may suffer serious mental or physical impairment.

Any condition not included in the newborn screening program is not an Inherited Metabolic Disorder.

INJURY means a condition caused by accidental means which results in damage to the Plan Member's body from an external force and independently of all other causes and which is **NOT** related to occupation or employment. Chewing accidents are **NOT** considered Injuries. Muscle strain due to athletic activity or other exertion is considered a Sickness under the Plan.

INPATIENT means that a Plan Member is confined as a registered bed patient in a Hospital, Skilled Nursing Facility, or other covered facility.

INSTITUTIONAL HEALTHCARE PROVIDER means healthcare providers including an Ambulatory Surgical Center, Home Health Care Agency, Hospice, Hospital, Skilled Nursing Facility or Urgent Care Facility.

INTENSIVE CARE UNIT means a specialized section, ward or wing, within a Hospital which is operated exclusively for critically ill patients (other than Hospice patients) and provides special supplies, equipment and constant observation and care by registered professional nurses or other highly trained Hospital personnel, excluding any Hospital facility maintained for the purposes of providing normal post-operative recovery treatment or service.

MAINTENANCE CARE means continued care to maintain the optimum state of health after the Plan Member has reached a maximum level of recovery.

MASTER PLAN DOCUMENT means the Plan Document detailing the provisions of the Plan.

MEDICAID means the medical benefits provided by Title XIX of the Social Security Act, as amended.

MEDICALLY NECESSARY or **MEDICAL NECESSITY** means that a service, medicine or supply is necessary and appropriate for the diagnosis or active treatment of an Injury or Sickness based on generally accepted current medical practice.

To be Medically Necessary, Covered Expenses must:

1. Be rendered in connection with an Injury or Sickness;
2. Be consistent with the diagnosis and treatment of the Plan Member's condition; and
3. Be in accordance with the standards of good medical practice.

To be Medically Necessary, Covered Expenses must also be provided at the most appropriate level of care and in the most appropriate type of health care facility. Only the Plan Member's medical condition (not the financial status or family situation, the distance from a facility or any other non-medical factor) is considered in determining which level of care or type of health care facility is appropriate. Medically Necessary is the criterion by which the Plan determines the necessity of medical service and treatment under this Plan.

A service, medicine or supply will **NOT** be considered Medically Necessary if:

1. It is provided only as a convenience to the Plan Member or provider;
2. It is not appropriate treatment for the Plan Member's diagnosis or symptoms;
3. It exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
4. It is part of a plan of treatment that is considered to be Experimental/Investigational/Investigative in the diagnosis or treatment of an Injury or Sickness;

5. It involves the use of a drug or substance not formally approved by the United States Food & Drug Administration, even if approval is not required.

The fact that any particular Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

MEDICARE means the medical benefits provided by Title XVIII of the Social Security Act, as amended.

MENTAL/NERVOUS DISORDER(S) means a psychiatric or emotional disorder recognized as such by the American Psychiatric Association. "Mental/Nervous Disorders" include but is not limited to: psychotic, bi-polar, psychoneurotic disorders.

NURSE MIDWIFE means a person certified as a Nurse-Midwife to assist with childbirth under the direction and supervision of a licensed Physician.

OUTPATIENT means treatment rendered to a Plan Member at: a clinic; an Ambulatory Surgical Center; a Physician's office; or at a Hospital or other covered facility, other than as an overnight bed patient.

PAYMENT PERCENTAGE means the amount payable by the Plan for Covered Expenses after satisfaction of the Deductible amount or Copay amount, if applicable. The Payment Percentage is shown in the Schedule of Coverage.

PHYSICIAN means a legally licensed doctor of medicine and Surgery, doctor of optometry, psychiatrist, osteopathy, podiatric medicine, surgical chiropody, chiropractic, or doctor of dental Surgery. A Physician shall not include the Plan Member or any member of his/her Immediate Family.

PLAN means the Plan of benefits offered by the Employer according to the provisions of the Master Plan Document.

PLAN YEAR means the twelve month period beginning from the effective date of this Plan. This Plan's Plan Year is July 1st through June 30th. The Plan Year may not be the same as the Coverage Year.

PLAN OF HOME HEALTH CARE for purposes of the Home Health Care benefit means a program for continued care and treatment of the Plan Member established and approved in writing by the Plan Member's attending Physician within 7 days following termination of a Hospital confinement as a resident Inpatient, and which is for the same or related condition for which the Plan Member was hospitalized. The attending Physician must certify, and recertify every 90 days, that the proper treatment of the Injury or Sickness would require continued confinement as a resident Inpatient in a Hospital or in a Skilled Nursing Facility in the absence of the services and supplies provided as part of the Plan of Home Health Care.

PLAN MEMBER means an Employee or Dependent, as defined in the Master Plan Document, who is covered by the Plan.

PREFERRED PROVIDER ORGANIZATION (PPO) means a specific group of healthcare providers who have joined together in an arrangement to provide medical services on a more favorable basis in terms of price and utilization than is generally offered to the public on an individual practitioner basis.

PRIMARY CARE PHYSICIAN means a Family Practitioner, General Practitioner, Pediatrician, OB/GYN, Internal Medicine Specialist, or Chiropractor.

PROTECTED HEALTH INFORMATION (PHI) means health information that is created or received by a Covered Entity, including the Plan, and relates to:

1. A person's past, present or future physical or mental health;
2. Provision of health care to that person; or
3. Past, present or future payment for that person's health care.

To be considered Protected Health Information the information must be "individually identifiable health information" which means that in addition to the above requirements, the health information must identify the individual or a reasonable basis must exist to believe that an individual can be identified using the information. Protected Health Information covers information in any form (electronic, oral or written).

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) means a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Plan

Member or eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address of the Plan Member and the name and mailing address of each such Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

In addition, a National Medical Support Notice (NMSN) shall be deemed a QMCSO if it:

1. Contains the information set forth below;
 - a. Name of an issuing state agency;
 - b. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Plan Member) or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate recipient(s);
 - c. Identity of an underlying child support order;
2. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated;
3. Informs the Plan Administrator that, if a group health plan has multiple options and the Plan Member is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and
4. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated Dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to Plan

Members, except to the extent necessary to meet the requirements of a state law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

REHABILITATION FACILITY means a facility accredited by the Joint Commission on the Accreditation of Health Care Organizations or the Commission on the Accreditation of Rehabilitative Facilities as a Rehabilitation Facility for the primary purpose of physical rehabilitation. This facility may also be a ward, floor or other area contained within a Hospital whose primary purpose is physical rehabilitation.

RESCISSION or **RESCIND** means a cancellation of coverage or discontinuance of coverage under the Plan that has retroactive effect. Such action is prohibited under Health Care Reform unless attributable to (a) a failure to timely pay the cost of coverage, or (b) fraud or intentional misrepresentation of material fact, as those circumstances are described under Health Care Reform and regulatory guidance.

RESPITE CARE means care provided to a Plan Member receiving Covered Services for Hospice care, for the purpose of giving the Plan Member's uncompensated primary caregivers relief when necessary in order to maintain the Plan Member at home.

ROUTINE means any physical examination, including all related x-ray and laboratory tests, or any other medical procedure performed when the Plan Member is asymptomatic (i.e., which are **NOT** Medically Necessary for the diagnosis of a specific Injury or Sickness), including those performed on a Physician's recommendation due to the patient's family history.

SCHEDULE OF COVERAGE means the Schedule at the beginning of the Master Plan Document, or as later amended, which specifies the level of benefits provided by the Plan.

SECOND SURGICAL OPINION means a second opinion to evaluate the need for elective Surgery previously recommended by the patient's Physician provided that:

1. The charges that would be made for the recommended Surgery, if performed, must qualify as Covered Expenses;
2. The Physician furnishing the second opinion must not be financially associated with the Physician rendering the first opinion, and must be Board Certified in the appropriate medical specialty except: a Board

Certified specialist is not required if the Physician has been recommended to the patient by a local medical society; and

3. The second opinion must be set forth in writing by the second Physician after the examination of the patient.

SICKNESS means a disorder of the body, a disease, condition, Mental/Nervous Disorder(s), Substance Abuse, pregnancy, or complication of pregnancy. All Sicknesses which are due to the same cause or to a related cause or causes will be deemed to be a Sickness.

SKILLED NURSING FACILITY means a place, or a distinct part of a place, which meets all of the following criteria:

1. It is licensed according to state or local laws;
2. Its chief purpose is to provide skilled nursing treatment to a Plan Member who is recovering from an Injury or Sickness;
3. It includes areas for medical treatment;
4. It provides 24-hour nursing service under the full-time supervision of a Physician or a graduate registered nurse (R.N.);
5. It maintains daily health records for each patient;
6. It has an agreement which provides for the services of a Physician;
7. It has a suitable method for providing drugs and medicines to patients;
8. It has an arrangement with one or more Hospitals for the transfer of patients;
9. It has an effective utilization review plan;
10. Its functions are developed with the advice and review of a skilled group which includes at least one Physician;
11. It is **NOT** solely a place for:
 - a. Rest, rehabilitation or Custodial Care;
 - b. The aged;

- c. Treatment of Substance Abuse; or
- d. Those who are mentally handicapped or who have Mental/Nervous Disorders.

SPECIALIST means a Physician other than a Primary Care Physician.

SUBSTANCE ABUSE means the overuse or addiction to alcohol and/or other drugs to the extent that is physically or mentally detrimental to the Plan Member, **EXCLUDING** nicotine and/or caffeine overuse or addiction.

SUMMARY HEALTH INFORMATION may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

SURGERY means:

- 1. The performance of generally accepted operative and cutting procedures. This includes related surgical supplies, specialized instrumentations, endoscopic examinations and other invasive procedures.
- 2. The correction of fractures and dislocations.
- 3. Injections of medication into joints and bursae for nerve blocks or as an alternative to Surgery, and injections of sclerosing agents and dyes used for radio-opacity.
- 4. Usual and related pre-operative and post-operative care.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ) AND/OR MYOFASCIAL PAIN DYSFUNCTION (MPD) means jaw joint conditions including craniomandibular disorders; and all other conditions of the joint linking the jaw bone, skull; and the complex of muscles, nerves and other tissues related to that joint.

TERMINALLY ILL or TERMINAL ILLNESS means a Plan Member has an incurable diagnosis and medical prognosis of limited life expectancy, usually 6 months or less.

URGENT CARE CENTER means a facility engaged primarily in providing minor emergency and episodic medical care. A board-certified Physician, a registered nurse, and a registered x-ray technician must be in attendance when the facility is open. The facility must include x-ray and laboratory equipment and life support equipment. For the purpose of this Plan, a facility meeting these requirements will be considered an Urgent Care Center, by whatever name it may be called.

USUAL, CUSTOMARY AND REASONABLE FEE means a charge for a given service by a provider to the majority of his clients, but such charge must be one which is within the range of fees charged by the majority of providers of similar training and experience, for that service within a specific, limited geographic or socioeconomic area as determined by the Plan. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill or expertise.

The term "area" as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross-section of a level of expenses.

The Usual, Customary and Reasonable Fee for surgical procedures mean Covered Expenses for the services of a Physician for performing an operation.

SECTION D

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

EMPLOYEE ELIGIBILITY DATE

For new Employees, coverage becomes available on the first of the month following the date of hire.

Employee absences due to health related factors will be credited toward the eligibility waiting periods. **NOTE:** The Plan will give credit for any waiting periods satisfied in whole or in part under the Employers' previous plan of benefits.

The above requirement regarding length of employment shall be waived in any instance where a Plan Member is merely changing from Dependent status to Employee status, or vice versa. In these instances, coverage shall continue without interruption.

If an Employee loses coverage in this Plan due to Injury, Sickness, layoff, or Employer approved leave of absence and returns to work for the Employer within 3 months of the loss of coverage, he/she will be eligible for coverage on the date of return to work and will **NOT** have to satisfy a new waiting period.

NOTE: If an Employee does not enroll for coverage under this Plan when he/she is initially eligible to enroll for coverage, he/she may enroll for coverage under this Plan at a later date subject to the Special Enrollment Period or the Open Enrollment Period, as explained elsewhere in the Plan Document.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

Coverage becomes effective on the date the eligibility requirement is satisfied, provided the Employee has enrolled for coverage within 30 days from the date he/she first satisfied the eligibility requirements.

DEPENDENT ELIGIBILITY DATE

An Employee becomes eligible for Dependent coverage on the later of:

1. The date the Employee becomes covered;
2. The date the Employee acquires an eligible Dependent; or

3. The date the Employee is required, by a Qualified Medical Child Support Order or by an administrative process established under state law, to provide Dependent coverage.

DEPENDENT EFFECTIVE DATE OF COVERAGE

A Dependent whose coverage is required under a medical support order will be eligible to participate in the Plan as of the date specified in the order, provided the medical support order satisfies the requirements of Arizona law. The Employer will review a medical support order and determine whether it is qualified under Arizona law. Upon request to the Employer, Members may obtain a copy of the procedures governing medical support order determinations, which is available at no charge.

All other Dependent coverage will become effective on the first of the month following one month from the Employee's date of hire. If Dependent status is acquired after the Employee's initial eligibility, the effective date of coverage shall be one month following the month in which the new Dependent becomes eligible for coverage under the Plan, provided the Employee completes a change form and submits it to the Employer within thirty (30) days after the attainment of Dependent status.

Individuals who become an eligible Dependent of an Employee after the Employee's Effective Date of coverage will be eligible for coverage as explained under the CHANGE IN STATUS provision.

NOTE: If an Employee does not enroll his/her eligible Dependents for coverage under this Plan when they are initially eligible to be enrolled for coverage, the Employee may enroll his/her eligible Dependents for coverage under this Plan at a later date subject to the Special Enrollment Period or the Open Enrollment Period, as explained elsewhere in the Plan Document.

CHANGE IN STATUS

If an Employee is covered for single coverage and wants to change to family coverage because of a change in marital status, he/she must request family coverage within 31 days of the date of marriage, in order for coverage to become effective on the date of the marriage.

Should an Employee's marital status change due to divorce or legal separation, notification of that change must be given to the Employer within 60 days of the date of that change.

Employees who have single coverage may request a change to family coverage to add an eligible Dependent child, by submitting a new enrollment form within 31 days of acquiring the child as an eligible Dependent, in which case the child's coverage would become effective on the date he/she became an eligible Dependent of the Employee.

Notwithstanding the foregoing, with respect to an Employee who acquires a new Dependent via birth, adoption, or placement for adoption, coverage for the new Dependent shall begin immediately upon birth, adoption, or placement for adoption and shall not be conditioned upon the enrollment of the new Dependent. However, if an additional premium is charged for the new Dependent and if the new Dependent fails to enroll within the thirty-one (31) day time period referenced above, the coverage shall cease upon expiration of such time period. Even if no additional premium is charged, the Employee should notify the Employer of the birth, adoption, or placement for adoption.

Any request for coverage after the 31 days will be subject to the Special Enrollment Period provision or the Open Enrollment Period.

SPECIAL ENROLLMENT PERIOD

If an Employee declines coverage for himself/herself or for his/her Dependents (including the Employee's spouse) because of other health coverage, the Employee will be able to enroll himself/herself and/or his/her Dependents in this Plan at a future date, provided that the Employee requests coverage within 31 days after other coverage ends. Coverage becomes effective on the first of the month following the date on which the request for enrollment was received by the Employer.

This special enrollment period **ONLY** applies to individuals whose prior Creditable Coverage:

1. Was under COBRA and they exhausted that COBRA coverage; or
2. Was not under COBRA and they lost that prior Creditable Coverage due to:
 - a. events that are similar to COBRA qualifying events (including, but not limited to loss of eligibility as a result of legal separation, divorce, death, termination or reduction in hours of employment or a child aging out under other parent's coverage);
 - b. the plan no longer offering any benefits to a class of similarly situated individuals (e.g. part-time employees);
 - c. the cessation of the employer contributions for that prior Creditable Coverage (actual termination of other coverage is not required);
 - d. moving out of an HMO's service area; or
 - e. reaching a lifetime limit for all benefits.

However, loss of eligibility does **NOT** include a loss due to failure of the individual to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

An Employee must make a request for Special Enrollment within 31 days of the loss of the previous Creditable Coverage and must supply the Plan with proof of loss of coverage under the other group health plan.

Additional Special Enrollment rights exist for Employees and their Dependents (who are eligible but not enrolled for coverage) upon either (1) termination of Medicaid or the State Children's Health Insurance Program (SCHIP) coverage resulting from loss of eligibility; or (2) becoming eligible for premium assistance in this Plan under a Medicaid or SCHIP program. In order to be entitled to this Special Enrollment right, the Employee must request coverage within 60 days of termination or the date the parent or child is determined to be eligible for assistance.

In addition, if an Employee, who declined coverage in this Plan for himself/herself or for his/her Dependents, acquires a new Dependent as a result of marriage, birth, adoption, or placement for adoption, the Employee will be allowed to enroll for coverage for himself/herself and/or his/her spouse and/or the new child, provided that the Employee requests coverage within 31 days after the marriage, birth, adoption or placement for adoption.

EXAMPLES:

1. In the case of marriage, an Employee who had previously declined coverage could become covered, with or without his/her spouse, under the Special Enrollment Period provision. Coverage becomes effective on the date of marriage.
2. In the case of birth or adoption, an Employee and/or his/her spouse, who had previously declined coverage in this Plan could become covered under the Special Enrollment Period provision. Coverage becomes effective on the child's date of birth, adoption or placement for adoption.

NOTE: During a Special Enrollment, the Employee may add a new Dependent under the Employee's current plan option or the Employee may switch to another option, **if applicable** (e.g., an Employee who is covered under this Plan may switch to an HMO plan offered by the Employer or change from one option under this Plan to another option under this Plan).

OPEN ENROLLMENT PERIOD

If an Employee declines coverage for himself/herself or for his/her Dependents (including the Employee's spouse) at the time such individuals are eligible for coverage, the Employee will be able to enroll himself/herself and/or his/her eligible Dependents during any Open Enrollment Period. Each year, during the month of **May**, the Employer will offer an Open Enrollment Period to eligible individuals (Employees and Dependents) who are not already covered under this Plan. Any individual enrolling for coverage under this Plan during an Open Enrollment Period (other than a new Employee who has not yet satisfied his/her eligibility-waiting period) will have coverage effective on the first of July.

NOTE: An Employee's eligible Dependent(s) may **NOT** be covered under this Plan unless the Employee is also covered. (This limitation does not apply to COBRA coverage.)

CHOOSING PLAN OPTIONS

Every year, during the month of May, the Employer will offer an annual enrollment period, during which an Employee who is presently enrolled under one Plan Option may elect to become enrolled in an alternate Plan Option. The effective date of the change in Plan Option will be July 1.

Employees who are presently enrolled under one Plan Option may also elect to become enrolled in an alternate Plan Option if they experience a family status change. A family status change will occur if the Employee gains or loses an eligible Dependent due to divorce, death, loss of eligibility, birth, marriage, adoption or a child reaching the maximum age limit.

Dependents covered by that Employee must be covered under the same Plan Option.

TERMINATION OF INDIVIDUAL COVERAGE

Coverage under this Plan shall terminate at midnight on the earliest of the following:

1. The date the Plan is terminated for all Plan Members;
2. The date a required contribution, if any, is due but the Plan Member fails to make the contribution;
3. With regard to a specific benefit, on the date the benefit is terminated or deleted from the Plan;
4. The date the Plan Member requests termination of any or all coverage under the Plan, subject to IRS Cafeteria rules. The request for termination must be in writing and all forms required by the Plan Administrator must be completed;

5. For Employees: If an Employee does not work the required number of hours to be considered an eligible Employee for any reason other than those specifically listed above, (i.e.; voluntary or involuntary termination of employment; or reduction in hours), coverage will terminate at the end of the month in which the Employee ceases full-time active work;
6. For Dependents:
 - a. Coverage will terminate on the same day as coverage terminates for the Employee under whom they are covered;
 - b. Coverage will terminate at the end of the month in which the individual no longer meets the Plan's Definition of an eligible Dependent;
 - c. For Dependents whose coverage became effective upon their birth, adoption, or placement for adoption under Change in Status, coverage will terminate on the date thirty-one (31) days from the effective date of coverage if an additional premium is charged for the new Dependent and the new Dependent fails to enroll with-in thirty-one (31) days following the birth, adoption, or placement for adoption.
 - d. Coverage will terminate on the date as specified in the Qualified Medical Child Support Order or by an administrative process established under state law if eligibility for Dependent coverage is solely based on this order.

NOTE: Coverage shall be canceled automatically, without notice, if a Plan Member:

1. Attempts, through deceit, to obtain benefits that otherwise would not be provided by this Plan; or
2. Attempts to obtain benefits for someone not entitled to benefits under this Plan.

Rescission. Coverage under this Plan may be Rescinded under certain circumstances. A determination by the Plan that a Rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Plan Member whose coverage is being Rescinded will be provided a 30 day notice period as described under Health Care Reform and regulatory guidance. Such notice shall be considered an Adverse Benefit Determination. At the conclusion of the 30 day notice

period, coverage shall be terminated retroactive to the date identified in the notification. Claims incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims.

This Plan shall at all times be in compliance with the applicable state family medical leave act and/or the Family and Medical Leave Act (FMLA) of 1993, or as later amended, provided the Employer is required to comply with such acts. The FMLA will run concurrently with any extension of coverage specified above.

SECTION E

CONTINUATION OF COVERAGE UPON INDIVIDUAL TERMINATION (COBRA)

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan ("Plan") offer Employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform Plan Members and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. The following paragraphs generally explain COBRA coverage, when it may become available and what a Qualified Beneficiary needs to do to protect his or her right to receive it.

We use the pronoun "you" in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a Qualified Beneficiary.

WHAT IS COBRA CONTINUATION COVERAGE? COBRA coverage is a temporary extension of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event". Specific Qualifying Events are listed below in the section entitled "What is a Qualifying Event".

The Plan has the following components, Medical and Prescription Drugs, and you may be enrolled in one or more of these components. COBRA (and the description of COBRA coverage contained in the plan document and summary plan description "SPD") applies only to the group health plan benefits offered under the Plan (the Medical and Prescription Drugs) and not to any other benefits offered by the Employer (such as life insurance, disability income, or accidental death or dismemberment benefits).

COBRA coverage is the same coverage that the Plan gives to other Plan Members under the Plan who are not receiving COBRA coverage. Each Qualified Beneficiary who elects COBRA will have the same rights under the Plan as other Plan Members covered under the component or components of the Plan elected by the Qualified Beneficiary, including Open Enrollment and Special Enrollment rights.

If an Employer offers more than one level of benefits and also offers an Open Enrollment Period (during which time, Plan Members are allowed to change to a different level of benefits or to add additional coverage, such as dental or vision), Qualified Beneficiaries must also be allowed to make these selections during an Open Enrollment Period.

In considering whether or not to take COBRA, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. You will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not obtain continuation coverage for the maximum time available to you. You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the Qualifying Event. You will also have the same special enrollment right at the end of continuation coverage if you obtained continuation coverage for the maximum time available to you.

WHO IS A QUALIFIED BENEFICIARY? In general, a Qualified Beneficiary is:

1. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the spouse of a covered Employee, or a Dependent child of a covered Employee.
2. A child born to, adopted by, or placed for adoption with a covered Employee during a period of COBRA coverage is considered to be a Qualified Beneficiary provided that, if the covered Employee is a Qualified Beneficiary, the covered Employee has elected COBRA coverage for himself/herself. The child's COBRA coverage begins when the child is enrolled in the Plan, including when enrolled through a Special Enrollment or an Open Enrollment.
3. A child who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO), received by the Employer during the covered Employee's period of employment with the Employer, is entitled to the same rights to elect COBRA as an eligible Dependent child of the covered Employee.

If however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer coverage constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes not only common-law Employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his/her performance of services for the Employer sponsoring the Plan (e.g., self-employed individuals, independent contractors, owners or corporate directors).

WHAT IS A QUALIFYING EVENT? If you are a covered **Employee** you will be entitled to elect COBRA if you lose your group health coverage under the Plan because of either of the following Qualifying Events:

1. your hours of employment are reduced; or
2. your employment ends for any reason other than your gross misconduct.

If you are a covered **spouse** of an Employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because of any of the following Qualifying Events:

1. your spouse dies;
2. your spouse's hours of employment are reduced;
3. your spouse's employment ends for any reason other than his/her gross misconduct;
4. your spouse becomes entitled to Medicare; or
5. you become divorced or legally separated from your spouse. Also, if your spouse (the Employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event for you even though your coverage was reduced or eliminated before the divorce or legal separation.

If you are a covered **Dependent child** of an Employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because of any of the following Qualifying Events:

1. the Employee dies;
2. the Employee's hours of employment are reduced;
3. the Employee's employment ends for any reason other than his/her gross misconduct;
4. the Employee becomes entitled to Medicare;
5. the parents of the Dependent child become divorced or legally separated; or
6. you stop being eligible for coverage under the Plan as a Dependent child.

If an Employee takes FMLA leave and does not return to work at the end of the leave,

the Employee (and the Employee's spouse and Dependent children, if any) will be entitled to elect COBRA if:

1. they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and
2. they will lose Plan coverage within 18 months because of the Employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave.)

If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the Employee and Dependents will be entitled to COBRA coverage even if they failed to pay the Employee portion of the contribution for coverage under the Plan during the FMLA leave.

WHEN IS COBRA COVERAGE AVAILABLE? When the Qualifying Event is the end of employment, reduction of hours of employment, or death of the Employee, the Plan will offer COBRA coverage to Qualified Beneficiaries. You need not notify the Employer of any of these three Qualifying Events. An Election Form will automatically be provided.

For the other Qualifying Events (divorce or legal separation of the Employee and spouse, or a Dependent child losing eligibility for coverage as a Dependent child), a COBRA Election Form will be sent to you only if you notify the Employer in writing within 60 days after the date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the Qualifying Event.

WHAT IS THE ELECTION PERIOD AND HOW LONG MUST IT LAST? An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Employer's Plan. A Plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of his/her right to elect COBRA continuation coverage.

HOW MAY COBRA COVERAGE BE ELECTED? To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA election notice and submit it to the COBRA Administrator.

Mail, hand-deliver or fax the completed Election Form to:

COBRA/Eligibility Department
EBSO, Inc.
2145 Ford Parkway, Suite 200
St. Paul, Minnesota 55116-1912
(651) 695-2500 or 1-800-486-7664
Fax number (651)695-1648

The Election Form must be completed in writing and mailed, hand-delivered, or faxed to the individual at the address/fax number specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; electronic communications, including e-mail messages; and faxed communications (unless they are on a proper Election Form).

If mailed, your Election Form must be postmarked (and if hand-delivered or faxed, your Election Form must be received by the individual at the address/fax number specified above) no later than 60 days after the date of the COBRA election notice provided to you at the time of your Qualifying Event. **IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.**

Each Qualified Beneficiary (including a child who is born to, adopted by or placed for adoption with a COBRA covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage. Covered Employees and spouses (if the spouse is a Qualified Beneficiary) may elect COBRA on behalf of all of the Qualified Beneficiaries, and parents may elect COBRA on behalf of their children.

Qualified Beneficiaries may be enrolled in one or more group health components of the Plan at the time of a Qualifying Event. If a Qualified Beneficiary is entitled to a COBRA election as the result of a Qualifying Event, he/she, may elect COBRA under any or all of the group health components of the Plan under which he/she was covered on the day before the Qualifying Event.

When you complete the Election Form you must notify the Employer if any Qualified Beneficiary has become enrolled under Medicare (Part A, Part B, or both) and, if so, the date of Medicare enrollment. If you become enrolled under Medicare (or first learn that you are enrolled under Medicare) after submitting the Election Form, immediately notify the Employer of the date of your Medicare enrollment at the address specified for delivery of the Election Form.

Qualified Beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are enrolled under Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing

COBRA, he/she becomes enrolled under Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied). See the section entitled “When may a Qualified Beneficiary’s COBRA continuation coverage be terminated?”.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the COBRA Administrator.

If you reject COBRA before the due date, you may change your mind as long as you furnish a completed Election Form before the due date.

WHAT ARE THE MAXIMUM COVERAGE PERIODS FOR COBRA CONTINUATION COVERAGE? The maximum coverage periods are based on the type of Qualifying Event and the status of the Qualified Beneficiary, as shown below:

1. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
2. In the case of a covered Employee’s enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
 - a. 36 months after the date the covered Employee becomes enrolled in the Medicare program. For example, if a covered Employee becomes enrolled under Medicare eight months before the date on which his employment terminates, COBRA coverage under the Plan for his spouse and Dependent children who lost coverage as a result of his termination can last up to 36 months after the date the Employee became enrolled under Medicare, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months). This COBRA coverage period is available only if the covered Employee becomes enrolled under Medicare within 18 months **BEFORE** the termination or reduction of hours; or
 - b. 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee’s termination of employment or reduction of hours of employment.

3. In the case of any other Qualifying Event than those described above, the maximum coverage period ends 36 months after the Qualifying Event.

In the case of a Qualified Beneficiary who is a child born to, adopted by or placed for adoption with a COBRA covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born, adopted or placed for adoption.

UNDER WHAT CIRCUMSTANCE CAN THE MAXIMUM COVERAGE PERIOD BE EXPANDED? If the Qualifying Event that resulted in your COBRA election was the covered Employee's termination of employment or reduction in hours, an extension of the maximum coverage period may be available if a Qualified Beneficiary is disabled or a second Qualifying Event occurs. You must notify the Employer of a disability or a second qualifying event in order to extend the period of COBRA coverage. **FAILURE TO PROVIDE NOTICE OF A DISABILITY OR SECOND QUALIFYING EVENT WILL ELIMINATE THE RIGHT TO EXTEND THE PERIOD OF COBRA COVERAGE.**

1. **Disability extension of COBRA coverage.** If a Qualified Beneficiary is determined by the Social Security Administration to be disabled and you notify the Employer in a timely fashion, all of the Qualified Beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for Qualified Beneficiaries who are receiving COBRA coverage because of a Qualifying Event that was the covered Employee's termination of employment or reduction in hours. The disability must have started at some time before the 61st day after the covered Employee's termination of employment or reduction of hours (this includes disabilities that began prior to the Employee's termination of employment or reduction of hours). The disability must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each Qualified Beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if you notify the Employer in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- a. the date of the Social Security Administration's disability determination;
- b. the date of the covered Employee's termination of employment or reduction of hours; or
- c. the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered

Employee's termination of employment or reduction of hours.

You must provide the Social Security Administration's determination notice within 18 months after the covered Employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

2. **Second Qualifying Event extension of COBRA coverage.** An extension of coverage will be available to spouses and Dependent children who are receiving COBRA coverage if a Second Qualifying Event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered Employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a Second Qualifying Event occurs is 36 months. Such Second Qualifying Events may include the death of a covered Employee, divorce or legal separation from the covered Employee, or a Dependent child's ceasing to be eligible for coverage as a Dependent under the Plan. These events can be a Second Qualifying Event only if they would have caused the Qualified Beneficiary to lose coverage under the Plan if the first Qualifying Event had not occurred. (This extension is not available under the Plan when a covered Employee becomes enrolled under Medicare.)

This extension due to a Second Qualifying Event is available only if you notify the Employer in writing of the Second Qualifying Event within 60 days after the later of:

- a. the date of the Second Qualifying Event; or
- b. the date on which the Qualified Beneficiary would lose coverage under the terms of the Plan as a result of the Second Qualifying Event (if it had occurred while the Qualified Beneficiary was still covered under the Plan).

WHAT IS THE COST OF COBRA CONTINUATION COVERAGE? The amount a Qualified Beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the group health Plan for coverage of a similarly situated Plan Member who is not receiving COBRA coverage (including both Employer and Employee contributions). The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

WHAT ARE THE COBRA CONTINUATION COVERAGE PAYMENT PROCEDURES? If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage no later than 45 days after the date of your election. (This is the date your Election Form is postmarked, if mailed, or the date your Election Form is received by the individual at the designated

address/fax number, if hand-delivered or faxed.) See the section above entitled “How may COBRA coverage be elected?”

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make the first payment. (For example, your employment terminates on September 30, and you lose coverage on September 30. You elect COBRA coverage on November 15. Your initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of your COBRA election.) You are responsible for making sure that the amount of your first premium payment is correct. You may contact the Employer using the contact information provided under the section entitled “How may COBRA coverage be elected?” to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, YOU WILL LOSE ALL COBRA RIGHTS UNDER THE PLAN.

After you make your first payment for COBRA coverage you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each Qualified Beneficiary will be disclosed in the election notice provided to you at the time of your Qualifying Event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. Following your election of COBRA coverage, you will receive a packet of 12 coupons to submit with your monthly COBRA premium. Periodic notices of payments due for these coverage periods will not be sent (that is, a monthly bill will not be sent to you for your COBRA coverage – it is your responsibility to pay your COBRA premiums on time).

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, YOU WILL LOSE ALL RIGHTS TO COBRA COVERAGE UNDER THE PLAN.

All COBRA premiums must be paid by check or money order. CASH WILL NOT BE ACCEPTED.

Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to:

COBRA/Eligibility Department
EBSO, Inc.
2145 Ford Parkway, Suite 200
St. Paul, Minnesota 55116-1912
(651) 695-2500 or 1-800-486-7664
Fax number (651)695-1648

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand-delivering a check if your check is returned due to insufficient funds or otherwise.

WHEN MAY A QUALIFIED BENEFICIARY'S COBRA CONTINUATION COVERAGE BE TERMINATED? COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can terminate before the end of the maximum coverage period for several reasons, which are described below.

COBRA coverage will automatically terminate before the end of the maximum coverage period if:

1. timely payment is not made to the Plan with respect to the Qualified Beneficiary. **NOTE:** Invalid payments (i.e., checks returned due to insufficient funds) will result in retroactive termination of coverage.
2. the Employer ceases to provide any group health plan (including successor plans) to any Employee.
3. a Qualified Beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the Qualified Beneficiary have been exhausted or satisfied).
4. a Qualified Beneficiary first becomes enrolled under Medicare benefits (Part A, Part B, or both) after electing COBRA.

5. during a disability extension period, the disabled Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled.

You must notify the Employer in writing within 30 days if, after electing COBRA, a Qualified Beneficiary becomes enrolled under Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the Qualified Beneficiary have been exhausted or satisfied). COBRA coverage will terminate (retroactively, if applicable) as of the date of Medicare enrollment or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any pre-existing condition exclusions for a pre-existing condition of the Qualified Beneficiary). The Employer will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare enrollment or other group health plan coverage.

If a disabled Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Employer of that fact within 30 days after the Social Security Administration's determination. If the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all Qualified Beneficiaries will terminate (retroactively, if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled. The Employer will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice that the disabled Qualified Beneficiary is no longer disabled. (For more information about the disability extension period, see the section above entitled "Under what circumstances can the maximum coverage period be expanded?")

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a Plan Member not receiving COBRA coverage (such as fraud).

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

DOES A QUALIFIED BENEFICIARY HAVE A DUTY TO KEEP THE PLAN INFORMED OF ADDRESS CHANGES? In order to protect your family's rights, you must keep the Employer and the Plan's Claims Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Employer and the Plan's Claims Administrator.

QUESTIONS? If you have questions about your COBRA continuation coverage, you should contact the Employer or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA).

Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

CONTACTS: You may obtain information about COBRA coverage on request from:

1. **The Employer (Plan Administrator):**

City of San Luis
1090 E. Union Street
San Luis, AZ 85349
928-341-8547

2. **COBRA Administrator:**

COBRA/Eligibility Department
EBSO, Inc.
2145 Ford Parkway, Suite 200
St. Paul, Minnesota 55116-1912
(651) 695-2500 or 1-800-486-7664
Fax number (651)695-1648

The contact information for the Plan may change from time to time. The information will be included in the Plan's most recent SPD (if you are not sure whether this is the Plan's most recent SPD, you may request the most recent one from the Employer).

YOU MUST GIVE NOTICE OF CERTAIN QUALIFYING EVENTS

If you or your Dependent(s) experience any of the following qualifying events, you or your Dependent(s) must notify the Plan Administrator/COBRA Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would end as a result of the qualifying event:

- your divorce or legal separation.
- your child no longer qualifies as a Dependent under the Plan.
- the occurrence of a secondary qualifying event as described in "Second Qualifying Event extension of COBRA coverage" (this notice must be received prior to the end of the initial 18-month or 29-month COBRA period). See "Disability extension of COBRA coverage" for additional notice requirements.

Notice must be made in writing and must include: the name of the Plan; name and address of the Employee covered under the Plan; name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g. divorce decree, birth certificate, disability determination, etc.).

Warning: If your notice is late, or if it is not completed and provided to the Employer as required, no Qualified Beneficiary will be offered the opportunity to elect COBRA coverage.

SECTION F

UNIFORMED SERVICES CONTINUATION AND REINSTATEMENT PROVISION

Continuation

A Plan Member who:

1. Is employed by the Employer;
2. Is determined by the Employer to be eligible for benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA);
3. Is absent from his/her position of employment with the Employer by reason of service in the uniformed services; and

4. Would otherwise have his/her coverage under the Plan terminated,

may elect to continue the coverage under the Plan that the Plan Member and his/her eligible covered Dependents had prior to such absence for a period not to exceed the lesser of:

1. The twenty four month period beginning on the date on which the Plan Member's absence begins; or
2. The day after the date on which the Plan Member fails to apply for or return to a position of employment as specified by the Employer.

Reinstatement

Upon re-employment, coverage under the Plan will be reinstated for a person who was absent from his/her position of employment with the Employer by reason of service in the uniformed services, as well as for his/her eligible Dependents who were covered Plan Members under the Plan at the time the absence began provided that:

1. The person was a covered Plan Member under the Plan until the time his/her absence from employment with the Employer commenced by reason of service in the uniformed services;
2. The person makes application for re-employment within the time limit specified by the Employer; and

3. At the time the person makes application for re-employment, he/she is entitled to benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

In such instances, an exclusion of the Plan or waiting period will not be applied, if that exclusion of the Plan or waiting period would not have been applied had coverage not been terminated as a result of service in the uniformed services. This also applies to any eligible Dependent of the covered person who becomes covered by the Plan as a result of such reinstatement of coverage.

An exclusion or waiting period may be imposed for any Injury or Sickness determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of service in the uniformed services.

SECTION G

GENERAL LIMITATIONS AND EXCLUSIONS

The Plan will not provide benefits for the following, **UNLESS** specifically stated otherwise in this Plan:

1. **Abortions.** Elective abortion unless carrying the fetus to full term would seriously endanger the life of the mother. If complications arise after the performance of any abortion, charges incurred to treat those complications will be eligible, whether the abortion was eligible or not.
2. **Absence from Hospital.** Charges made by a Hospital for a period of time when a registered bed patient is absent from the Hospital (e.g., weekend passes).
3. **Acupuncture.** Acupuncture, except as specifically listed otherwise in the Plan.
4. **After the Termination Date.** Charges after the Plan Member's termination from the Plan.
5. **Alternative Care.** Any service or supply not generally accepted in medical practice in the United States as necessary and appropriate for the diagnosis or treatment of the condition of the patient. For example, the following services shall be considered unaccepted charges for the purposes of this Plan, except as specified in the Covered Expenses:
 - a. Aroma therapy;
 - b. Bioenergetic therapy;
 - c. Biofeedback;
 - d. Carbon dioxide therapy;
 - e. Chelation therapy (unless due to heavy metal poisoning);
 - f. Homeopathy, herbal therapy, or naturopathy;
 - g. Megavitamin therapy;
 - h. Nutritional based therapy;

- i. Primal therapy;
 - j. Psychodrama;
 - k. Vision perception training.
6. **Anonymous support groups.**
7. **Athletic/Health Clubs.** Charges for enrollment in an athletic, health or similar club. Health club memberships and all services provided by a health club facility, air conditioners, room humidifiers, room dehumidifiers, air purifiers, food blenders, exercise equipment, orthopedic or therapeutic mattresses (except hospital-type beds or pressure-relieving mattresses as prescribed by a Physician), home or automobile modification, environmental change, pools, whirlpools, and similar items, even if recommended, ordered or prescribed by a Health Care Professional.
8. **Autopsies** and related charges.
9. **Blood and Blood Donor.** Processing, storage and administration charges related to self-donated blood for potential transfusion to the Plan Member unless incurred after the Plan Member is scheduled for surgery. Services of a blood donor.
10. **Breast Prostheses.** Charges for purchase of breast prostheses, except following a Medically Necessary mastectomy, in which case charges for breast prostheses (one unit per side per Calendar Year per Plan Member) will be covered.
11. **Cardiac Rehabilitation.** Phase III and Phase IV Outpatient cardiac rehabilitation programs. Phase III cardiac rehabilitation begins at the completion of Phase II and may continue for six months or more. The program consists of group education at a community exercise facility, Hospital or clinic, or may be a home exercise program. Phase IV cardiac rehabilitation is a non-medically supervised maintenance program.
12. **Claim Forms.** Expenses for completion of claim forms or for preparation of medical reports; for missed appointments or for computer, internet, and telephone consultations.
13. **Clergy.** Services of the clergy.
14. **Coma stimulation programs.**
15. **Cosmetic.** Cosmetic Procedures for beautifying purposes unless reconstructive Surgery is necessitated by an accidental Injury or Sickness,

or Surgery is needed to restore normal bodily function due to a birth defect. Breast reduction, unless Medically Necessary or following a Medically Necessary mastectomy. Reconstruction of the other breast to produce symmetrical appearance will be covered in the case of a unilateral mastectomy. Breast augmentation, except following a Medically Necessary mastectomy. Reconstruction of the other breast to produce symmetrical appearance will be covered in the case of a unilateral mastectomy.

16. **Court-Ordered Care.** Charges for health care ordered by the court (i.e. court ordered rehabilitative treatment or services), unless otherwise covered under the Plan.
17. **Criminal Activities.** Charges Incurred for treatment of an Injury or Sickness sustained while the Plan Member is participating in an illegal occupation; commission of, or an attempt to commit, a felony; or voluntary participation in a riot, insurrection or civil disobedience.
18. **Custodial or Maintenance Care.** Custodial Care or domiciliary care, Maintenance Care, rest cures, convalescent care, a place for the aged or a nursing home.
19. **Dental Care.** Dental care (**EXCEPT** for any dental procedures specifically covered by this Plan).
20. **Duplicate.** Duplicate services or supplies.
21. **Durable Medical Equipment.** Replacement or repair of Durable Medical Equipment, prosthetics or orthotics which are stolen; lost; or damaged or destroyed by Plan Member misuse, abuse, or carelessness. Charges for equipment, models, or devices having features over and above that which best meets the Medical Necessity of the Plan Member. Motor vehicles, lifts for wheelchairs, motorized wheelchairs, lifts for scooters or stair lifts. Standard over-the-counter batteries.
22. **Employer Facilities** - Services and supplies provided through a medical department, clinic or other facility provided by or maintained by the Plan Member's employer for the exclusive use of that employer's employees, or a medical clinic or similar facility for which services or supplies are or should be available without charge to the Plan Member.
23. **Environmental Change.** Inpatient confinement, when such confinement is primarily for environmental change or rest.
24. **Excess of Maximum Benefit.** Charges in excess of any maximum benefit stated in the Plan.

25. **Excess of Usual, Customary and Reasonable Fee.** For expenses made which are in excess of the Usual, Customary and Reasonable Fee.
26. **Exercise Programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
27. **Experimental.** Charges for services and supplies, which are Experimental/Investigational/Investigative. This exclusion does not apply to covered Routine Patient Costs incurred by a Plan Member who participates in an Approved Clinical Trial. Routine Patient Costs include all items and services consistent with the coverage provided in the plan that is typically covered for a Plan Member who is not enrolled in a clinical trial. Routine patient costs do not include 1) the investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis.
28. **Extended Institutional Healthcare Provider.** Extended Institutional Healthcare Provider stays for reasons other than Medical Necessity or the attending Physician has documented that care could be provided in a less acute care setting.
29. **Family Counseling.** Family counseling, unless Medically Necessary or the family counseling is part of Medically Necessary treatment for a minor child Plan Member that has been recommended by a Health Care Professional treating the minor child.
30. **Financial or legal** counseling services.
31. **Foot Care.** Charges related to the following conditions:
 - a. Weak, unstable or flat feet, bunions, unless an open cutting operation is performed;
 - b. Treatment of corns, calluses or toenails, unless at least part of the nail matrix is removed. This does **NOT** apply when treatment is Medically Necessary due to diabetes or peripheralvascular disease;
 - c. Orthopedic shoes, orthotics, arch supports or any such similar device which is not custom made.

- 32. **Genetic Counseling.** Genetic testing or counseling when it is solely intended to be informational to a Plan Member or when it is used solely to answer questions or clarify issues that would not prevent the deterioration of a Plan Member's condition and directly impact the treatment being delivered to the Plan Member.
- 33. **Government.** Expenses Incurred by a Plan Member that may be covered or reimbursed by any public program, or by any national, state, provincial, county, or local government or any other political subdivision, instrumentality or agency thereof, except Medicare and Medicaid.
- 34. **Government Operated Facilities** - Services furnished to the Plan Member in any veteran's Hospital, military Hospital, institution or facility operated by the United States Government, by any state government, by any agency or instrumentality of such government, or any foreign government agency, for which the Plan Member has no legal obligation to pay for services rendered or expenses Incurred, **EXCEPT** services incurred and billed for non-service related conditions or for care or service furnished by a tax supported state Hospital for treatment of Mental/Nervous Disorders.
- 35. **Hair Loss.** Care and treatment for hair loss including hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.
- 36. **Hair Pieces.** Wigs and artificial hair pieces, unless related to a Sickness or Injury covered by this Plan.
- 37. **Halfway houses, wilderness programs,** group homes, or summer camps.
- 38. **Hearing Care.** Routine hearing care, except as stated otherwise under Preventive Care.
- 39. **Hemantitics.**
- 40. **Home Infusion Services.** Nursing services to administer home infusion therapy the Plan Member or another caregiver can be successfully trained to administer. Home infusion services that do not involve direct Plan Member contact, such as delivery charges and record-keeping.
- 41. **Hospital Employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and who is paid by the Hospital or facility for the service.
- 42. **Housekeeping or meal services** in the Plan Member's home.

- 43. **Hypnotism.** Expenses for hypnotism.
- 44. **Iontophoresis.**
- 45. **Immediate Family.** Services performed by a person who is a member of the Plan Member's Immediate Family or who resides in the Plan Member's home.
- 46. **Incurred by Another.** Charges actually Incurred by other persons.
- 47. **Infirmary.** Infirmary and other healthcare charges from a school or other educational facility.
- 48. **Infertility/Fertility/Adoption.** Services, drugs, or supplies for the purpose of, or related to the treatment of infertility, including drugs and procedures for the promotion of conception (i.e., assisted reproductive technology (ART) procedures, including sperm banking, artificial insemination, in vitro fertilization (IVGF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT), with or without cryopreservation or frozen embryo transfer, including charges for donor ova or sperm), except the initial examination and tests required to diagnose infertility are Covered Expenses. Infertility medications.

Charges related to or in connection with adoption.

Charges related to or in connection with surrogacy.

Lamaze or other childbirth classes.

Services of a doula.

Charges for donor ova or sperm unless specifically covered under the Plan.

- 49. **Inpatient Diagnostic Services, Therapy or Observation.** Charges for Hospital room and board and general nursing care when the Plan Member is admitted primarily for therapy services, diagnostic study or medical observation and if the necessary care can properly be provided on an Outpatient basis.
- 50. **Marriage/Sex Counseling.** Services or supplies for religious, marital, relationship or sex therapy, counseling or training services.
- 51. **Massage Therapy.** Charges for massage therapy, rolfing, related services, unless specifically stated otherwise.

- 52. **No Legal Obligation.** Expenses for which the Plan Member has no legal obligation to pay or for an expense which would not have been made if the person did not have coverage under this Plan.
- 53. **Not Medically Necessary.** Expenses, of any kind, that are not in connection with or are not Medically Necessary for the treatment of a Sickness or Injury (unless specifically stated otherwise in this Plan).
- 54. **Not Recommended.** For any service or supply which is not recommended or approved by a Physician.
- 55. **Nurse Midwife.** Delivery services of a certified Nurse Midwife when performed at an unlicensed, unaccredited facility.
- 56. **Nutritional Supplements.** Outpatient nutritional supplements including home meals, food, food supplements, infant formulas etc., diets, vitamins, minerals, naturopathic or homeopathic services/substances, other nutritional supplies and over the counter electrolyte supplements, except as required for treatment of inborn errors of metabolism or enteral nutrition via tube.
- 57. **Over the Counter.** Ordinary over-the-counter items such as cotton balls/swabs, alcohol wipes, bandages and ace wraps. Over the counter home testing and monitoring supplies and devices unless used in the treatment of diabetes.
- 58. **Patient Education.** Services or supplies for education or training (this exclusion does **NOT** apply to diabetic self-management education programs); social skills training, developmental, educational, scholastic or vocational services or training, including but not limited to: computers and computer software programs, treatment for scholastic improvement, vocational training, visual coordination, motor coordination, and special education for the learning disabled. (**NOTE:** this does **NOT** apply to medically necessary therapy).
- 59. **Penile prosthesis/implants.**
- 60. **Personal Convenience Items.** Telephone, television, radio, guest trays, personal hygiene or convenience items (other than Hospital admission kits), take-home drugs following discharge from a Hospital, air conditioners, air purifiers, physical exercise equipment, and similar items.
- 61. **Personal Growth.** Expenses for personal growth/development, hypnotherapy, holistic medicine or other programs with an objective to provide complete personal fulfillment.

62. **Prescription Drugs/Medications.** Unless stated otherwise, medications and vitamins which may be purchased without a Physician's written prescription (over-the-counter medications), and food supplements. Drugs, biologicals and solutions not listed in the latest edition of the United States Pharmacopoeia, the National Formulary or the New and Non-Official drugs. Prescription drugs received on an Outpatient basis are limited to the benefits specifically described under the Prescription Drug Card Benefit, except as specifically stated otherwise.

Phone consultations for the purpose of reviewing records or renewing prescriptions.

63. **Prior to Effective Date.** Charges Incurred prior to a Plan Member's Effective Date under the Plan.
64. **Private Duty Nursing** services.
65. **Professional Certifications.** Charges for professional certification, licensure or the like.
66. **Prohibited by Law.** Services that are prohibited by law or regulation.
67. **Recreational Therapy.**
68. **Respite Care.** Respite Care, except as specifically listed in the Hospice Care benefit.
69. **Reversal of Sterilization.** Charges for reversal of a sterilization procedure.
70. **Safety/Sport Related Items –** Devices used specifically as safety items or to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, diversion therapy, work hardening, or general motivation.
71. **Self-care and self-help training.**
72. **Sensory integration deficit therapy.**
73. **Smoking Cessation. Except** as stated otherwise in the Plan, charges for services, supplies and for smoking cessation programs, or charges related to the treatment of nicotine addiction, including smoking deterrent patches.
74. **Social Worker.** Services of a social worker.

75. **Surrogacy** related to in connection with adoption.
76. **Taxes.** Charges for taxes or surcharges, other than those that a medical facility is legally required to make.
77. **Therapeutic Devices.** Therapeutic devices or appliances [including needles and syringes (except as diabetic supplies), support garments and other non-medicinal substances, regardless of intended use].
78. **Third Party Exams.** Physical examinations for research or obtaining licensure, employment or insurance.
79. **Tomosynthesis.**
80. **Transplants.** Charges for services, chemotherapy, supplies, drugs and aftercare for or related to transplants not specifically listed in the Plan.
- High dose chemotherapy with autologous bone marrow transplantation to treat breast cancer.
- Charges associated with the purchase of any organ.
- Services or supplies furnished in connection with the transportation of a living donor.
- Re-transplants within a 365 day period following the original transplant procedure.
- Fetal umbilical cord blood stem cell transplantation.
81. **Transsexual Surgery.** Charges Incurred for transsexual Surgery and for any treatment leading to or in connection with sexual transformation.
82. **Transportation.** Expenses related to transportation to or between healthcare facilities, except as specifically provided under the Ambulance benefit.
- Non-Emergency Ambulance services.
83. **Travel.** Travel or accommodations for health, whether or not recommended by a Physician.
84. **Unlicensed Providers.** Any services rendered by unlicensed/uncertified providers, if a license or certificate is required by law where the services are rendered, or services that are outside the scope of the license of a

provider. This **exclusion does not apply** to interpreter services if necessary to provide Covered Services to a Plan Member.

85. **Vision.** Expenses for eyeglasses, contact lenses, or for the fitting or examination of such, unless required due to intraocular Surgery or Injury to the eye or as stated otherwise in the Plan. Charges for confinement, treatment, service or materials for Kerato-Refractive Eye Surgery (Surgery to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea, including but not limited to radial keratotomy and keratomileusis Surgery) or LASIK Surgery.

Vision therapy or eye exercises.

Sunglasses (Including any colored or tinted lenses) or safety glasses.

Repair of lenses or frames.

Refractive cataract lenses after cataract surgery.

Drugs or medications of any kind related to Routine vision services.

86. **War/Military Service.** Services or supplies Incurred due to an Injury or Sickness caused by war or an act of war (whether declared or undeclared), nuclear explosion or nuclear accident or major nuclear disaster, or service in the armed forces of any country. An act of terrorism will not be considered an act of war, declared or undeclared.

87. **Weekend Admission.** Initial Friday, Saturday and Sunday room and board charges Incurred for Hospital confinement which begins on Friday, Saturday or Sunday. This exclusion does not apply to Emergency admissions, pregnancy or scheduled Surgery within the 24-hour period immediately following Hospital admission.

88. **Weight Loss.** Routine treatment of obesity, or weight control counseling (including fees, vitamins, nutrients, supplements, or exercise therapy) and any related diagnostic testing unless necessitated as the result of a specifically identifiable condition of disease etiology, except medical nutrition therapy is a Covered Service. Preventive screening and counseling are Covered Services as listed under Preventive Care benefits.

Gastric bypass surgery for weight loss (bariatric surgery) regardless of the reason.

89. **Worker's Compensation.** Expenses due to a work-related Injury or Sickness sustained while doing anything pertaining to any occupation or

employment for remuneration or profit for which all or part of the expense is payable by workers' compensation or similar law.

Notwithstanding the above exclusions, the Plan will not deny benefits for Covered Expenses for treatment of an Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

SECTION H PRE-CERTIFICATION

PRE-CERTIFICATION IS REQUIRED FOR THE FOLLOWING SERVICES:

- All non-Emergency Hospitalizations (including skilled nursing facility, inpatient rehabilitation and residential treatment facilities)
- Outpatient surgery
- Special Services, such as acupuncture, podiatry and TMJ
- CT Scans, Pet Scans and MRIs
- Hospice
- Home Health Care
- Durable Medical Equipment > \$750 or when rental exceeds 4 months
- Inpatient Rehabilitation/Habilitation services

FOR PRE-CERTIFICATION CALL EBSO-REVIEW, AT 1-800-426-9317. Non-compliance reduces benefits. If a Plan Member does not comply with Pre-certification when required, Covered Expenses will be reduced by a penalty of

PPO: \$500 per service or

Non-PPO: 50% of the total cost of the service.

This reduction is in addition to the Deductible.

Please be prepared to supply the following basic information:

1. Patient's name and date of birth
2. Employee's name, address and phone number
3. Physician's name and phone number
4. Name of the Hospital
5. Reason for the hospitalization
6. Date the hospitalization started
7. Employer's I.D. Number.

SECTION I

COMPREHENSIVE MAJOR MEDICAL BENEFITS

UNLESS SPECIFICALLY STATED OTHERWISE THE FOLLOWING SERVICES AND SUPPLIES ARE SUBJECT TO THE DEDUCTIBLE, PAYMENT PERCENTAGES AND MAXIMUM PAYMENT AMOUNTS SHOWN IN THE SCHEDULE OF COVERAGE, TO THE USUAL, CUSTOMARY AND REASONABLE FEE LIMITATION, TO THE GENERAL EXCLUSIONS AND LIMITATIONS, AND TO ALL OTHER PROVISIONS OF THE PLAN. ALL EXPENSES MUST BE INCURRED AS THE RESULT OF AN INJURY OR SICKNESS AND BE RECOMMENDED BY A PHYSICIAN AS MEDICALLY NECESSARY, UNLESS SPECIFICALLY STATED OTHERWISE.

NOTE: Claims may not be received or processed in the same order that a Plan Member has received service. The Deductible and Payment Percentage will be applied to covered services in the sequence that claims are submitted and processed for payment.

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your network provider. Their website and telephone number are listed on the back of your ID card.

To the extent an item or service is a Covered Expense under the Plan, and consistent with the Plan's reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan is prohibited from discriminating against a provider based on the provider's license or certification, as long as the provider is acting within the scope of the provider's license or certification under applicable state law.

COVERED EXPENSES

1. **Acupuncture.** Acupuncture services from licensed Acupuncture Health Care Providers.
2. **Allergy Testing, Injections and Serum.** Allergy testing, injections and serum when rendered by a Physician or Health Care Professional.

3. **Ambulance Services.** Emergency transportation by local professional ground or air ambulance service:
 - a. From the Plan Member's home, scene of accident or medical Emergency to a Hospital; or
 - b. Between Hospitals and/or Skilled Nursing Facility.

Transportation is limited to the nearest facility equipped to treat the condition.

4. **Anesthetics.** Anesthetics and their administration when rendered in connection with an eligible surgical procedure and when administered by an anesthetist, anesthesiologist, Physician or by a registered nurse (under supervision of a Physician).
5. **Autism.** Charges for the treatment of Autism.
6. **Birthing Centers.** Charges made by a Birthing Center are covered on the same basis as if the charges had been made by a general Hospital.
7. **Blood Services.** Blood services, including whole blood, blood components, and blood processing administration. The Plan will not pay for the whole blood or blood components when donated or otherwise replaced by or on behalf of the patient.
8. **Chiropractic Care.** Includes x-rays, manipulations and supportive care. Supportive care means treatment, which is Medically Necessary to prevent the Plan Member's condition from significantly deteriorating. Maintenance care is Routine and is not Medically Necessary for the treatment of a condition. Maintenance care is **NOT** covered by the Plan. Chiropractic care is payable and **LIMITED** as shown in the Schedule of Coverage.
9. **Circumcisions.** Circumcisions (including Routine circumcisions) and the related charges for all male Plan Members.
10. **Clinical Trial Routine Patient Costs** incurred by a Qualified Individual who participates in an Approved Clinical Trial. If a Plan Member is covered under a PPO Plan, as shown on the Schedule of Coverage, a Qualified Individual who wishes to participate in an Approved Clinical Trial must use a PPO Provider if a PPO Provider is participating in the trial and the PPO Provider accepts the Qualified Individual as a participant in the trial. However, if a Plan Member is covered under a PPO Plan, and the Approved Clinical Trial is either conducted outside the state in which the

Qualified Individual resides by a Non-PPO Provider or there is no PPO Provider conducting the Approved Clinical Trial and accepting the Qualified Individual in the individual's state of residence, then Routine Patient Costs will be covered as if provided by a PPO Provider.

For the purpose of this Benefit, the following definitions apply:

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV Clinical Trial that is (1) conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and (2) is one of the following:

- a. Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - i. The National Institutes of Health.
 - ii. The Centers for Disease Control and Prevention.
 - iii. The Agency for Health Care Research and Quality.
 - iv. The Centers for Medicare & Medicaid Services.
 - v. A bona fide Clinical Trial Cooperative group or center of any of the entities described in clauses i) through iv) above or the Department of Defense or the Department of Veterans Affairs.
 - vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - vii. Any of the following in clauses a. – c. below if the following conditions are met: The study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - a) The Department of Veterans Affairs
 - b) The Department of Defense
 - c) The Department of Energy; or
- b. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- c. The study or investigation is a drug trial that is exempt from the investigational new drug application requirements.

Life-threatening Condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Qualified Individual means a Plan Member who meets the following conditions:

- a. The individual is eligible to participate in an approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening diseases or conditions.
- b. Either:
 - i. The referring health care provider has concluded that the Plan Member's participation in the Clinical Trial would be appropriate based upon the Plan Member meeting the conditions described in paragraph a. above; or
 - ii. The Plan Member provides medical and scientific information establishing that participation in such trial would be appropriate based upon the Plan Members meeting the conditions described in paragraph a. above.

Routine Patient Costs means all items and services that are typically covered by the Plan for a Qualified Individual who is not enrolled in a Clinical Trial. Routine Patient Costs do not include:

- a. The investigational item, device, or service, itself;
- b. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

11. **Dental Services.** This is not a comprehensive dental plan. Covered Services under the Plan include only the following dental services or oral maxillofacial services that relate to a Plan Member's medical condition:

- a. Treatment of acute, accidental, traumatic Injuries to sound, natural teeth (including replacement of avulsed teeth due to traumatic complications) or jaws. Coverage is for an Injury that results from external trauma to face and mouth only, not for cracked or broken teeth which result from biting or chewing.

The following are Covered Services under the Plan only if they are a direct result of the Injury:

- i. dental implants;
- ii. orthodontia;
- iii. fixed or removable dental prosthetic devices, including crowns, bridges, and dentures;
- iv. corrections of malocclusions.

b. Coverage for oral surgery is limited and includes the following Covered Services under the Plan:

- i. Oral surgical treatment of, and orthodontic services related to the management of cleft lip or cleft palate for Dependents up to age 18.

The following are Covered Services under the Plan only if they are a direct result of the cleft lip or cleft palate:

- dental implants;
- orthodontia (If a Dependent child covered under the Plan is also covered under a dental plan which includes orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services.);
- fixed or removable dental prosthetic devices, including crowns, bridges, and dentures;
- or corrections of malocclusions.

- ii. Oral surgery for tumors or cysts of the jawbone or mouth.

The following are Covered Services under the Plan only if they are a direct result of the illness:

- dental implants;
- orthodontia;
- fixed or removable dental prosthetic devices, including crowns, bridges, and dentures;
- corrections of malocclusions.

- iii. Oral surgery for the removal of bony impacted or partially bony impacted teeth.

- iv. Osseous surgery.

c. Medically Necessary treatment of temporomandibular disorder (TMJ/TMD), up to a \$300 Maximum Lifetime Benefit under the Plan, including:

- i. Non-surgical treatment:
 - medical management pain relief;
 - “trigger point” injections;
 - physical therapy;

- cognitive behavioral therapy;
 - relaxation therapy, including biofeedback;
 - Botox injections.
 - ii. Surgical treatment to correct functional problems of the jaw:
 - oral maxillofacial surgery;
 - orthognathic surgery, including occlusal equilibration.
12. **Diabetic Education.** Diabetic education and training for self-management programs for Plan Members with diabetes.
13. **Dialysis services.** Charges for dialysis, wherever performed. Charges for supplies and rental of dialysis equipment for home dialysis. This does **NOT** include charges for set-up or for furniture.
14. **Foot Conditions.** Charges for treatment for the following foot conditions:
- a. Metatarsalgia or bunions when an open cutting operation is performed;
 - b. Corns and calluses or toenails when at least part of the nail root is removed or due to peripheralvascular disease.
15. **Home Health Care Agency.** Charges made by a Home Health Care Agency for services rendered to a Plan Member due to an Injury or Sickness. Eligible Home Health Care Services begin on the day of initial treatment by a Home Health Care Agency. No amount will be payable for Home Health Care charges unless the following conditions are met:
- a. Continued confinement in a Hospital or Skilled Nursing Facility would have been required if Home Health Care had not been available;
 - b. The care at home is Medically Necessary and is not primarily for Custodial Care;
 - c. The treatment at home is for the same illness or related condition that made the Hospital and Skilled Nursing Facility confinement necessary;
 - d. A Physician must have given a written order for Home Health Care Services.

Covered Services shall consist of:

- a. Part-time or intermittent nursing care by or under the supervision of a Registered Professional Nurse (RN);

- b. Part-time or intermittent services of a home health aide;
- c. Physical, occupational or speech therapy;
- d. Dietary guidance; and
- e. Medical supplies, medical appliances, medical equipment, drugs and/or medications prescribed by the attending Physician. These services may be provided on an Outpatient basis by a Home Health Care Agency, by a Hospital or other facility under an arrangement with a Home Health Care Agency.

Services not covered under the Home Health Care benefit include, but are not limited to: dietitian services, homemaker services, maintenance therapy, dialysis treatment, purchase or rental of dialysis equipment, food or home delivered meals.

Benefits are limited to the maximums set forth in the Schedule of Coverage. A Home Health Care visit shall consist of four hours of service provided through the Home Health Care Agency.

16. **Hospice Care.** Charges made for Hospice Care when performed as part of a Hospice program are included as Covered Expenses. Hospice Care is care rendered to a Terminally Ill Plan Member by or under arrangements with a Hospice Agency.

Covered charges by a Hospice facility, Hospital, convalescent facility or Hospice Agency shall include:

- a. Room and board and services/supplies furnished to a Plan Member while an Inpatient for pain control and other acute and chronic symptom management; and
- b. The following services and supplies furnished to a Plan Member while not confined as an Inpatient.
 - i. Part-time or intermittent nursing care by a registered nurse (RN), licensed practical nurse (LPN) or home health aide for up to 8 hours in any day.
 - ii. Medical social services provided to the Hospice patient and his/her Immediate Family:

- a) Assessment of the Plan Member's social, emotional and medical needs, and the home and family situation.
- b) Identification of the community resources which are available.
- c) Assisting the Plan Member in obtaining those resources needed to meet his/her assessed needs.
- d) Psychological and dietary counseling.
- e) Consultation or case management services by a Physician.
- f) Physical and occupational therapy.
- g) Medical supplies, drugs, and medicines prescribed by a Physician.
- h) Bereavement counseling provided by a licensed social worker or a licensed pastoral counselor. Benefits are limited to the maximums set forth in the Schedule of Coverage.
- i) Benefits for Respite Care are limited to five days during which twelve or more hours of respite services are provided.

Not included are charges made for:

- a. Funeral arrangements.
- b. Financial or legal counseling which includes estate planning or the drafting of a will.
- c. Homemaker or caretaker services which are not solely related to care of the Plan Member, including sitter or companion services for either the Plan Member who is ill or other members of the family, transportation, housecleaning and maintenance of the house.
- d. Pastoral counseling.

17. **Inpatient Hospital Services.** Hospital charges for Hospital Miscellaneous Expenses, wards, semi-private rooms, cardiac care (including Phase I cardiac rehabilitation while the Plan Member is an Inpatient), Intensive

Care Units, nursery rooms for newborn sick and well babies, and private rooms, (provided such confinement is Medically Necessary for the Plan Member's condition or provided the Hospital **ONLY** has private rooms). If private room confinement is not Medically Necessary for the Plan Member's condition, the Plan will consider as a Covered Expense an amount equal to the Hospital's semi-private room rate. If the Hospital only has private rooms, the Plan will consider as a Covered Expense an amount equal to the Hospital's least expensive room rate.

For any covered maternity, the Plan will not limit benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require notification of a length of stay not in excess of the above periods.

NOTE: When the delivery is outside of the Hospital, the minimum period of Hospital stay begins when the mother or newborn is admitted. The attending Physician will determine whether an admission is in connection with childbirth, and thereby eligible for the minimum length of stay.

18. **Maternity Care.** Maternity Care including Outpatient facility services and Physician medical and surgical services (including office visits) for normal pregnancy, miscarriage, and complications of pregnancy.

This benefit is available to all Plan Members. Additional benefits may be covered under Preventive Care benefits and are available to all Plan Members.

Note: Charges Incurred for maternity Inpatient admissions are payable under the Inpatient Hospital services benefit.

This benefit will also include the services of a certified Nurse-Midwife for care performed under the direction and supervision of a licensed Physician. The supervising Physician shall be identified and the cost of supervision is a reimbursable expense. Total fees cannot exceed the fee the Physician would have charged had he provided the entire service.

Services provided in connection with the birth of a child who is legally adopted by a Plan Member if all of the following are true:

- a. the Dependent was adopted within one year of his/her birth;
- b. the Plan Member is legally obligated to pay the costs of the adopted Dependent's birth;
- c. the Plan Member has satisfied all applicable limitations set forth in this Plan; and

- d. the Plan Member has notified the Employer of the Plan Member's acceptability to adopt children under Arizona law within sixty (60) days of the later of:
 - i) receipt of approval from the State, or
 - ii) becoming covered under the Plan.

19. Medical foods and Amino Acid-based Formula.

- a. Medical foods: The maximum annual benefit for medical food to treat an Inherited Metabolic Disorder is \$5,000 per Member per Coverage Year.
- b. Amino acid-based formula: The maximum annual benefit for amino acid-based formula to treat eosinophilic gastrointestinal disorder is \$20,000 per Member per Coverage Year.

20. Medical Supplies/Durable Medical Equipment/Prosthetics/Orthotics.
Covered Services under the Plan Include the following types of Medically Necessary Durable Medical Equipment, Prosthetics, Orthotics and Disposable Supplies, when prescribed by a Health Care Professional.

- a. home renal dialysis equipment and supplies;
- b. equipment necessary to treat respiratory failure;
- e. diabetic supplies (i.e., insulin, insulin syringes/needles, test tape and chemstrips), including insulin infusion pumps, only to the extent that these items are not covered under the Prescription Drug Card Benefit. Insulin pumps are limited to one insulin pump per Plan Member per Calendar Year;
- f. blood glucose monitoring devices for diabetic Plan Members, only to the extent that these items are not covered under the Prescription Drug Card Benefit (limited to one blood glucose monitoring device per Plan Member per Calendar Year);
- g. blood pressure monitoring equipment;
- h. inhalation devices;
- i. apnea monitoring devices;
- j. oxygen and other gases including rental of equipment for their administration.
- k. equipment and supplies used in connection with parenteral and intravenous therapy covered by the Plan;
- l. Jobst sleeves, stockings and gloves are covered only for post-phlebitic conditions or post-surgical edema, and coverage is limited to one item per affected body part per Coverage Year unless the item has outlived its useful life or must be replaced to accommodate bodily growth. (maximum benefit of 2 (two) per Plan Member per Coverage Year);

- m. wigs and artificial hair pieces worn for hair loss resulting from alopecia areata or other Sickness or Injury covered by the Plan;
- n. bronchial drainage systems that employ a chest percussion vest and vest compressor;
- o. bone growth stimulators;
- p. post mastectomy bras that accommodate a breast prosthesis (maximum benefit of 7 (seven) bras per Plan Member per Coverage Year);
- q. Home cervical traction unit;
- r. Light therapy devices for seasonal affective disorders and dermatologic conditions;
- s. the first purchase of glasses or contacts for aphakia, keratoconus or following cataract Surgery.
- t. Hearing aid (limit of 1 per Plan Member per Calendar Year).
- u. the purchase, fitting, adjustments and repairs of prosthetic devices and supplies that:
 - i. Replace all or part of a missing body part and its adjoining tissues;
 - ii. Aid in the function of a malfunctioning body part.

Repair or replacement of the above will be covered only if it is shown that the repair or replacement is due to a change in the Plan Member's physical condition or it is less costly to buy a replacement than to repair the existing prosthesis.

- v. Orthotics
- w. Disposable supplies and other supplies customarily provided by prescription and Medically Necessary for the treatment of a Sickness or Injury, including but not limited to needles, syringes, surgical dressings, casts, splints, slings trusses, ostomy and colostomy supplies, catheters, and other similar items which serve only a medical purpose, unless covered under the Prescription Drug Card Benefit. Items usually stocked in the home for general use, such as adhesive bandages, petroleum jelly and thermometers are not covered.
- x. Rental (not to exceed the purchase price) or purchase (at the Plan's option) of **Durable Medical Equipment**. Covered Expenses for Durable Medical Equipment which are prescribed by a Physician will be covered while the Plan Member is receiving medical care. Covered Expenses are limited to the least expensive item, which is adequate for the Plan Member's needs.

Repair of Durable Medical Equipment. Separate charges for the repair of Durable Medical Equipment are Covered Expenses if such equipment is being purchased or is already owned by the Plan

Member and repair is necessary to make the equipment serviceable. When repair costs exceed the estimated cost for purchasing or renting the same item for the remaining period of medical need, such excess repair costs are not a Covered Expense. Rental of Durable Medical Equipment while a Plan Member's own Durable Medical Equipment is being repaired is a Covered Expense.

Replacement of Durable Medical Equipment. Durable Medical Equipment that a Plan Member owns, is purchasing, or renting may be replaced in the event of loss, irreparable damage (due to accident or natural disaster) or irreparable wear (i.e., deterioration due to usage over time, not due to a specific event) or when required because of a change in the Plan Member's medical condition or to accommodate bodily growth. Replacement of Durable Medical Equipment due to irreparable wear is not a Covered Expense during the reasonable useful lifetime of the Durable Medical Equipment; however repair costs up to the estimated cost of replacement of such equipment may be a Covered Expense. This plan reserves the right to re-evaluate Medical Necessity of Durable Medical Equipment associated with a request for replacement of such equipment.

- y. Medically Necessary **supplies used with covered medical equipment.**
- z. **Mechanical medical devices** placed in a body cavity to replace an internal organ or to aid the function of a body part, including but not limited to: pacemakers, artificial larynx, artificial hips and artificial knees.

- 21. **Mental/Nervous Disorders and/or Substance Abuse.** Charges for the treatment of Mental/Nervous Disorders and/or Substance Abuse when recommended by or under the clinical supervision of a licensed Physician or a licensed psychologist. Such treatment must be recognized as appropriate in accordance with broadly accepted standards of medical practice. Charges are payable as shown in the Schedule of Coverage.

Eligible Inpatient Services: Room & board and miscellaneous charges. Medical services including individual and group psychotherapy, psychological testing, family counseling, and convulsive therapy.

Day Hospitalization will be payable under this Plan.

Eligible Outpatient Services: Medical services including individual and group psychotherapy, psychological testing, family counseling, and charges by an approved treatment facility.

22. **Organ/Tissue Transplant Services.**

Autologous. When the source of cells is from an individual's own marrow or stem cells.

Allogeneic. When the source of cells is from a related or unrelated donor's marrow or stem cells.

Autologous Bone Marrow Transplant. When bone marrow is harvested from the individual and stored. The patient undergoes treatment which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is then re-infused (transplanted).

Allogeneic Bone Marrow Transplant. When bone marrow is harvested from a donor and stored. The patient undergoes treatment which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is re-infused (transplanted).

Autologous/Allogeneic Stem Cell Support. A treatment process that includes stem cell harvest from either bone marrow or peripheral blood, tumor ablation with high-dose chemotherapy and/or radiation, stem cell re-infusion, and related care. Autologous/allogeneic bone marrow transplantation and high dose chemotherapy with peripheral stem cell rescue/support are considered to be autologous/allogeneic stem cell support.

Transplant Services. This is transplantation including re-transplants of the human organs or tissue listed below including all related post-surgical treatment and drugs and multiple transplants for a related cause. Transplant services do not include other organ or tissue transplants or surgical implantation of mechanical devices that function as a human organ, except surgical implantation of FDA approved Ventricular Assist Devices (VAD), functioning as a temporary bridge to heart transplantation.

Covered Services include services, supplies, Inpatient medications, and related aftercare (Including procedures to determine rejection or success of transplant) for **ONLY** the following human organ and bone marrow transplants and stem cell support procedures **expressly listed below**:

- a. Autologous Bone Marrow Transplant;
- b. Allogeneic Bone Marrow Transplant;
- c. Autologous/Allogeneic Stem Cell Support;

- d. heart, heart-lung, liver, lung (single or double), for end-stage kidney disease, and cornea transplants for end stage disease;
- e. partial organ transplants, including partial liver or partial pancreas;
- f. pancreas transplant for a diabetic with end-stage renal disease who has received a kidney transplant or will receive a kidney transplant during the same operative sessions or a medically uncontrollable, labile diabetic with one or more secondary complications, but whose kidneys are not seriously impaired.

Organ/tissue transplant service means any of the following services, which are Medically Necessary, and rendered to a Plan Member as such services relate to a covered organ/tissue transplant:

- a. Organ/tissue procurement (including typing and acquisition);
- b. Medical supplies/services and room and board in a Hospital or in an alternate treatment setting approved by the Plan;
- c. Drugs and Physician charges; and.
- d. Transportation, lodging and meals in relation to a covered organ transplant (limited to the Plan Member and one companion and the donor; applies only when the Plan Member receiving the transplant or the donor resides more than 50 miles from the transplant facility). There is a maximum lifetime benefit of \$10,000.00 per Plan Member for transportation, lodging and meals in relation to an organ transplant.

Donor Expenses:

If a transplant operation is determined to be a covered organ/tissue transplant procedure, Covered Expenses Incurred by a **donor** will be covered as follows:

- a. if the donor is not a Plan Member, but donates to a Plan Member, this Plan will be secondary to any other plan under which the donor is entitled to benefits for these expenses.
- b. if the donor is covered by this Plan, but the recipient is not, the recipient's plan will be primary for the donor's expenses and this Plan will be secondary. **THE RECIPIENT IS NOT ENTITLED TO BENEFITS UNDER THIS PLAN UNLESS HE/SHE IS A COVERED PLAN MEMBER.**

- c. if both the donor and the recipient are covered by this Plan, all Covered Expenses Incurred by each person will be treated separately for each person.

The following are not Covered Services under the Plan:

- a. services, chemotherapy, supplies, drugs and aftercare for or related to organ and bone marrow transplant and stem cell support procedures not specifically listed above as Covered Services;
- b. charges associated with the purchase of any organ;
- c. artificial organs, devices, or systems, whose purpose is to assist or replace a natural body organ, and any charges for the implantation, attachment or use of such organ, device or system, including follow-up care. This exclusion does not apply to kidney dialysis or pacemakers or cochlear implants. This exclusion does not apply to healthcare services or surgery for immediate life-threatening health problems as determined by the Plan or to charges in relation to artificial organs that may be necessary on a temporary short-term basis until a suitable donor organ is available;
- d. high dose chemotherapy with Autologous bone marrow transplantation to treat breast cancer;
- e. charges in connection with non-human organ or tissue transplants;
- f. services or supplies furnished in connection with the transportation of a living donor;
- g. travel expenses, except as stated above;
- h. re-transplants within a 365 day period following the original transplant procedure.

23. **Outpatient Facility Services.** Services and supplies received in connection with treatment rendered in the Outpatient department of a Hospital, **Urgent Care Center**, emergency room, emergency care clinic or **Ambulatory Surgical Center**.

24. **Physicians' Services.** The following services and supplies when performed by a Physician or any other properly licensed/certified Health Care Professional, while acting within the scope of his/her license/certificate, are considered Covered Expenses:

- a. Covered Expenses for **visits** made by a Physician to a Plan Member while confined as an **Inpatient** in a covered medical facility. Consultations when requested by the attending Physician, limited to one consultation per day per specialist. This includes Routine pediatric examinations of a newborn sick or well baby.
- b. Covered Expenses made by a Physician, for Hospital Outpatient services, **office visits or home visits** for diagnosis and treatment of a specific Injury or Sickness, including voluntary **second or third**

surgical opinions; immunizations and injections of medication (including the medication) related to a covered Injury or Sickness.

- c. **Surgical Services** - Eligible charges are covered for Surgery when performed in a Hospital, Outpatient department of a Hospital, Ambulatory Surgical Center, Physician's office or clinic.

For documented multiple surgical procedures the Plan shall cover the greater surgical procedure at 100% of the Usual, Customary and Reasonable Fee and 50% of the Usual, Customary and Reasonable Fee for each lesser procedure during the same operative session.

NOTE: Charges for the treatment of separate and distinct fractures and surgeries that require the skills of two or more surgeons who have different specialties and when each performs a separate operation are covered at 100% of the Usual, Customary and Reasonable Fee.

Covered Expenses include Hospital pre-operative and post-operative care. Covered Expenses for surgical services include, for example, the following:

- i. **Cosmetic Procedures** required as a result of an accidental Injury.
- ii. **Breast reconstruction** in connection with a mastectomy, including:
 - a) Reconstruction of the breast on which the mastectomy was performed;
 - b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - c) Prostheses and physical complications, all stages of mastectomy, including lymphedemas.
- iii. **Functional repair** or restoration of any body part when Medically Necessary to achieve normal body function. Charges for reconstructive or cosmetic surgery to restore bodily function or correct deformity related to a congenital anomaly in a child up to age eighteen (18);
- iv. Charges for an **assistant surgeon**.

- v. **Voluntary sterilizations**, including all related charges, for all Employees and Dependent spouses.

The word “visit” means a personal interview between the Plan Member and a Physician and does not include telephone calls or interviews in which the Physician does not see the Plan Member for treatment.

25. **Preventive Care Services.** Covered Expenses shall include Routine physical exams (including the related office visit) and the following services:

- a. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;
- b. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved;
- c. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- d. With respect to women, to the extent not described in 1 above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA.

Any changes to the recommendations or guidelines referred to above will not be deemed Preventive Services until the first day of the Plan Year beginning on or after the date that is one year after the new recommendation or guideline went into effect.

Covered Services are provided for Preventive Care, Including:

- a. Well-baby/child exams and routine periodic preventive exams, Including routine gynecological exams
- b. This includes required school and school athletic physicals and camp physicals
- c. Preventive care services in conjunction with a routine periodic preventive exam as outlined below
- d. Routine immunizations (Including immunizations for foreign travel)
- e. Routine hearing exams (limit of one exam per Plan Member per Coverage Year)
- f. Routine vision exams (limit of one exam per Plan Member per Coverage Year)

Preventive Care Services				AGES												
Covered preventive care services are limited to once per plan member per coverage year unless otherwise indicated.																
All Members				> 5	≥ 11	≥ 12	≥ 18	≥ 19	≥ 20	≥ 45	≥ 50	≥ 55	≥ 60	≥ 75	> 80	
Hepatitis C (HCV) screening for people at high risk for infection and one-time screening for people born between 1945 and 1965				X	X	X	X	X	X	X	X	X	X	X	X	
Hepatitis B (HBV) screening for people at high risk for infection				X	X	X	X	X	X	X	X	X	X	X	X	
Obesity screening and counseling				X	X	X	X	X	X	X	X	X	X	X	X	
Chlamydia, gonorrhea and syphilis screening					X	X	X	X	X	X	X	X	X	X	X	
High intensity behavioral counseling to prevent sexually transmitted diseases					X	X	X	X	X	X	X	X	X	X	X	
Human immunodeficiencyvirus (HIV) screening					X	X	X	X	X	X	X	X	X	X	X	
Human papillomavirus (HPV) screening – once every 3 years beginning at age 30										X	X	X	X	X	X	
Depression screening						X	X	X	X	X	X	X	X	X	X	
Diabetes screening							X	X	X	X	X	X	X	X	X	
High blood pressure screening							X	X	X	X	X	X	X	X	X	
Alcohol misuse screening and counseling								X	X	X	X	X	X	X	X	
Healthy diet for hyperlipidemia/risk for diet related chronic disease counseling								X	X	X	X	X	X	X	X	
Tobacco use behavioral interventions and FDA approved pharmacotherapy for adults who use tobacco								X	X	X	X	X	X	X	X	
Lipid panel once every 5 years									X	X	X	X	X	X	X	
Aspirin to prevent Cardiovascular Disease (CVD) and colorectal cancer*											X	X	X			
Colorectal cancer screening options (one of the following): - Fecal immunochemical test with flexible sigmoidoscopy every 5 years - Barium enema and flexible sigmoidoscopy every 5 years - CT Colonography every 5 years - Colonoscopy once every 10 years - Stool-based tests: fecal occult blood test, fecal immunochemical test, FIT-DNA (e.g. Cologuard) once per year											X	X	X	X	X	
Lung cancer screening with history of smoking												X	X	X		
Herpes zoster/shingles vaccine one time only													X	X	X	
Intensive behavioral counseling interventions to promote a healthful diet and physical activity for adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors							X	X	X	X	X	X	X	X	X	
Children's Health			Birth	2	3	5	6	7	9	10	11	12	18	19	20	21
Expanded newborn screen (blood)			X													
Phenylketonuria (PKU) once at birth			X													

Evoked otoacoustic emissions (EOAE) once at birth	X													
Prophylactic eye medication for gonorrhea once at birth	X													
Congenital hypothyroidism screening – one time only between birth and 1 year	X													
Sickle cell disease screening – one time only between birth and 1 year	X													
Iron supplements – between 6-12 months*	X													
Autism screening	X	X												
Developmental screening – up to four screenings between birth and 36 months	X	X	X											
Psychosocial/Behavioral assessment – up to four assessments between birth and 36 months	X	X	X											
Pediatric vision screening	X	X	X	X										
Dental caries chemoprevention, oral fluoride*	X	X	X	X	X									
Lead level screening	X	X	X	X	X									
Human Immunodeficiency virus (HIV) screening if at increased risk for HIV	X	X	X	X	X	X	X	X						
Tuberculin skin testing (TB)	X	X	X	X	X	X	X	X	X	X	X			
Hepatitis C virus (HCV) screening for members at high risk	X	X	X	X	X	X	X	X	X	X	X			
Developmental surveillance	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Hematocrit or Hemoglobin screening	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Metabolic/Hemoglobin	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Lipid panel		X	X	X	X	X	X	X	X	X	X	X		
Alcohol and Drug use assessment									X	X	X	X	X	X
Men's Health						≥ 18	≥ 45	≥ 65	> 75	≥ 80				
Vasectomy sterilization procedure						X	X	X	X	X				
Abdominal Aneurysm screening – one time only								X						
Women's Health						≥ 9	≥ 11	≥ 19	≥ 21	> 26	≥ 40	≥ 45	≥ 55	≥ 80
FDA approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity							X	X	X	X	X	X	X	X
Breast cancer chemoprevention counseling and treatment*								X	X	X	X	X	X	X
Counseling and testing related to BRCA with family history								X	X	X	X	X	X	X
Papanicolaou smear (once every 3 years age 40-65)									X	X	X	X	X	
Mammogram											X	X	X	X
Breast cancer screening											X	X	X	X
Osteoporosis screening												X	X	X
Preconception and Prenatal Care														
Folic acid supplements for members planning or capable of pregnancy*														
Bacteriuria screening for pregnant female – once per pregnancy														
Hepatitis B screening for pregnant female – once per pregnancy														

HIV screening for pregnant female			
Iron deficiency screening for pregnant female*			
RH Incompatibility screening for pregnant female – twice per pregnancy			
Syphilis screening for pregnant female			
Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period and costs for the purchase or rental of breastfeeding equipment, which includes the following: • Purchase of non-hospital grade electric or manual breast pump, once per pregnancy, which includes breast pump supplies for nursing women; • Rental of a hospital grade pump requires a prescription and prior authorization after the 3rd month of rental and may include Member cost-sharing.			
Gestational diabetes screening for pregnant women after 24 weeks of gestation			
Aspirin to prevent preeclampsia after 12 weeks of gestation in women who are at high risk for preeclampsia *			
Immunizations – Frequency and specific age guidelines in accordance with the Advisory Committee on Immunization Practices	≤ 6	≥ 7	≥ 19
Diphtheria, Tetanus, Pertussis (Tdap)*	X	X	X
Hepatitis A*	X	X	X
Hepatitis B*	X	X	X
Influenza*	X	X	X
Measles, Mumps, Rubella (MMR)*	X	X	X
Meningococcal*	X	X	X
Pneumococcal*	X	X	X
Inactivated Poliovirus (IPV)*	X	X	
Rotavirus*	X		
Haenophilus Influenza Type B*	X		
Human papillomavirus (HPV)*		X	X
Varicella*		X	X

* Items noted with an asterisk may be covered under the outpatient prescription drug benefit.

If a diagnosis is indicated after a routine Preventive Care exam, the exam will be payable under the Routine Preventive Care benefit; however, all healthcare services related to the diagnosis will be payable as any other illness. Coverage for Plan Members having additional risk factors, exhibiting a Sickness, or symptoms is provided under the Hospital and Physician benefits.

26. **Rehabilitation Facility.** Treatment in a Rehabilitation Facility when the treatment cannot be safely provided on an Outpatient basis. Charges made by an Inpatient Rehabilitation Facility are covered on the same basis as if the charges had been made by a general Hospital.
27. **Skilled Nursing Facility.** Charges by a Skilled Nursing Facility for confinement as an alternative to Hospital confinement. The same benefits available in a Hospital are available in a Skilled Nursing Facility when

prescribed by the attending Physician and the confinement is due to an Injury or Sickness.

Benefits are available only as long as necessary for the proper care and treatment of the Plan Member. The Plan may require written certification by the attending Physician as to the continuing need for skilled nursing care.

Plan Members are eligible for benefits under this provision while recovering from a Sickness or Injury requiring services of an intensity less than those available in an acute general Hospital but greater than those available at the Plan Member's home.

Benefits are limited to the maximums set forth in the Schedule of Coverage.

28. **Surcharges.** Charges for state imposed surcharges.

NOTE: If the Plan contains an exclusion for sales tax or other tax, the exclusion shall not be applicable to any surcharges.

29. **Therapies and/or Treatments.** Fees of a Hospital, Physician or Health Care Professional for services used to promote recovery from a Sickness or Injury for the following therapies and/or treatments:

- a. **Cardiac Rehabilitation** – Cardiac rehabilitation is limited to Phase I and Phase II. Phase I cardiac rehabilitation is a medically supervised multidisciplinary program covered under the inpatient Hospital benefit. Phase II cardiac rehabilitation usually begins upon dismissal from the Hospital and may continue for two weeks to three months. It is Physician directed and closely supervised by paramedical personnel. The program components include carefully prescribed exercise, education, counseling and risk-factor modification.
- b. **Chemotherapy** - The treatment of malignant disease by chemical or biological antineoplastic agents.
- c. **Occupational Therapy** - The treatment of a physically disabled Plan Member by means of constructive activities designed and adapted to promote the restoration of the Plan Member's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the Plan Member's particular occupational role.

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period

of time. No Benefits are provided for diversional, recreational or vocational therapies (such as hobbies, arts and crafts).

- d. **Physical Therapy** - The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neuro-physiological principles, and devices. Such therapy is performed to relieve pain, restore maximum function and to prevent disability following Sickness, Injury or loss of a body part.
 - e. **Radiation Therapy** - The treatment of disease by x-ray, radium, radon, roentgen or radioactive isotope.
 - f. **Respiratory or Inhalation Therapy** - The treatment of a condition by the administration of medicines, water vapors, gases or anesthetics by inhalation.
 - g. **Speech Therapy** - Expenses for speech therapy for restorative or rehabilitative speech therapy for speech loss or impairment due to an Injury or Sickness other than a functional nervous disorder, or due to Surgery performed as the result of an Injury or Sickness. If the speech loss is due to a congenital anomaly, Surgery to correct the anomaly must have been performed prior to the therapy.
30. **X-Rays or Laboratory Tests.** X-rays or laboratory tests recommended by a Physician or surgeon for diagnosis of a Sickness or Injury. This includes charges for Pre-admission Testing.

SECTION J

DEDUCTIBLE PROVISIONS

The Deductible amount can only be satisfied by Comprehensive Major Medical Covered Expenses. The Deductible applies to all Covered Expenses **UNLESS** specifically stated otherwise.

Once a family has collectively satisfied the family Deductible amount as shown in the Schedule of Coverage during a Calendar Year, no further Deductibles will be applied to Covered Expenses for other members of the family for the remainder of the Calendar Year.

The PPO Deductible will **NOT** be used to satisfy the Non-PPO Deductible, and vice versa.

ANNUAL OUT-OF-POCKET MAXIMUM BENEFIT

The Annual Out-of-pocket maximum is the total amount of Covered Expenses that are payable by the Plan Member, during a Calendar Year. It is comprised of the Deductible amount and Coinsurance. The maximum is shown in the Schedule of Coverage.

The PPO Annual Out-of-pocket maximum will **NOT** be used to satisfy the Non-PPO Annual Out-of-pocket maximum, and vice versa.

The Annual Out-of-pocket maximum does **NOT** include:

1. Charges Incurred for services and supplies which are not covered by the Plan.
2. Charges in excess of the Usual, Customary and Reasonable Fee.
3. Charges Incurred in excess of any maximum benefit listed in the Plan.
4. Any penalty payable by the Plan Member for non-compliance with the Pre-certification provision.

SECTION K

PPO OPTION

In order to receive benefits under the PPO Option, a Plan Member must receive treatment from a PPO provider. The Employer has PPO networks to offer health care services through specific Physicians, Hospitals and various other providers of service. The Plan offers a higher level of coverage for the expenses provided by PPO providers.

A listing of PPO network providers is available at no charge.

The Plan will pay for Covered Medical Expenses rendered by PPO providers based upon the approved amount of the charge by the PPO. Benefits are subject to the percentages listed in the Schedule of Coverage.

Responsibility for use of Preferred Providers

It is the Plan Member's responsibility to use preferred providers if the Plan Member wants to receive the higher level of benefits provided under this Plan.

The Plan Member is responsible for the difference between the Usual, Customary and Reasonable Fee and billed charges whenever Covered Services under the Plan are provided by a Non-PPO healthcare provider.

The following are the only additional circumstances in which the Plan Member will receive the higher level of benefits as specified in the Schedule of Coverage:

1. If Covered Services are not available through a PPO provider, then Non-PPO Covered Services will be paid at the PPO benefit level if Prior Authorization is obtained (the Plan Member will be responsible for the difference between the Usual, Customary, and Reasonable Fee and the billed charges).
2. If ancillary services and supplies (such as, but not limited to anesthesia, radiology, pathology, physical therapy, etc.) are rendered at a PPO facility regardless of whether the Physician or Health Care Professional providing the services is a PPO provider, provided however that the attending Physician is a PPO provider;
3. If the Plan Member is in an Emergency situation;
4. If treatment is received while traveling or residing outside the service area of the defined PPO provider network will be paid at the PPO percentage rate specified in the Schedule of Coverage.

NOTE: Non-PPO benefits will be paid for Covered Services incurred at a Non-PPO facility when admitted by a PPO Physician.

Continuity of Care.

Notwithstanding anything in this Plan to the contrary, in the event a Plan Member joins the Plan or a Health Care Professional ceases to be a PPO Provider, a Plan Member shall have the opportunity to continue receiving treatment from his/her Health Care Professional even though that Health Care Professional is not a PPO Provider as provided herein.

1. A new Plan Member may continue an active course of treatment for a life threatening disease or condition with a Health Care Provider who is not a PPO Health Care Provider for a transitional period of thirty (30) days from the effective date of the new Plan Member's coverage under the Plan.
2. In the event a new Plan Member has entered the third trimester of pregnancy, such new Plan Member may continue to receive care from a Health Care Professional who is not a PPO Health Care Professional for a transitional period beginning on the effective date of the new Plan Member's coverage under the Plan and ending upon the earlier of: (i) the cessation of care related to the delivery of the child, or (ii) six (6) weeks after the delivery.
3. A Plan Member may continue an active course of treatment for a life threatening disease or condition with a Health Care Professional who was terminated from the PPO for a transitional period of thirty (30) days from the date the Health Care Professional ceases to be PPO provider. In the event the Health Care Professional was terminated for reasons of medical incompetence or unprofessional conduct, this provision shall not apply.

In order for this continuity of care provision to apply, the Health Care Professional must agree in writing to accept, as payment in full, reimbursement at the rates established by the Plan, comply with the Plan's quality assurance and utilization review requirements, and comply with the Plan's policies and procedures relating to obtaining Prior Authorization. For a Health Care Professional who was terminated from the PPO, the rates shall be the rates applicable before the termination. For all other Health Care Professional, the rates shall not exceed the level of reimbursement applicable to similar services of Health Care Professional within the PPO. The Plan will not provide coverage for benefits not otherwise covered under this Plan.

SECTION L

PRESCRIPTION DRUG CARD BENEFIT

For additional information, please refer to the material provided by the Prescription Drug Card Administrator or contact them at the phone number listed on the prescription drug card. The Prescription Drug Card Administrator will be able to assist the Plan Member in determining the benefits, limitations and exclusions relative to the prescription drug card program, which may differ from the benefit, limitations and exclusion in this Plan.

SECTION M

CARE PROVIDED BY THE UNITED STATES GOVERNMENT

The Plan will reimburse for care rendered by the Veterans Administration for non-service connected disabilities, on the same basis as these services are otherwise covered by the Plan.

The Plan will reimburse for care rendered by the United States to military retirees and dependents who are covered by this Plan on an inpatient basis through a facility of the uniformed services, on the same basis as these services are otherwise covered under the Plan.

COORDINATION OF BENEFITS

The Plan contains a non-profit provision coordinating it with other Plans under which an individual is covered so that total benefits available will not exceed 100% of the Allowable Expense for the services. When this Plan pays second, it will pay, with respect to each claim submitted for payment, 100% of Allowable Expenses less whatever payments were actually made by the Plan (or Plans) that paid first.

An "Allowable Expense" means any health care service or expense, including coinsurance, copays or copayment and without reduction for any deductible, that is covered in full or in part by any of the Plan covering the person. Allowable Expenses do not include expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under this Plan.

"Claim Determination Period" means the time during any one benefit year when a person is covered and incurs charges for services or supplies covered under this Plan and one other plan.

As each claim is submitted, each plan determines its liability and pays or provides benefits based upon Allowable Expenses incurred during the Claim Determination Period. However, that determination is subject to adjustment as later Allowable Expenses are incurred during the same Claim Determination Period.

"Plan" means any plan providing health benefits or health services including but not limited to:

1. Group, blanket or franchise insurance coverage;
2. Group practices and other group pre-payment coverage;

3. Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans; and
4. Any coverage under governmental programs, such as Medicare, Tricare/CHAMPUS, and any coverage required or provided by any statute, such as no-fault auto insurance.

"Plan" shall not include:

1. School accident type coverage;
2. Hospital indemnity coverage; or
3. Individual insurance coverage.

EFFECT ON BENEFITS

Plans determine the sequence in which they pay benefits, or which plan pays first, by applying uniform order of benefit determination rules in a specific sequence. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC). Any Plan that does not use these same rules always pays its benefit first.

When two Plans cover the same person, the following order of benefit determination rules establish which Plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until the order of benefits is established. The rules are as follows:

Rule 1: Non-Dependent/Dependent

- A. The Plan that covers a person as an employee, retiree, member or subscriber (that is, other than as a dependent) pays first; and the Plan that covers the same person as a dependent pays second;
- B. There is one exception to this rule. If the individual is a Medicare beneficiary, then, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 1. Secondary to the plan covering the individual as a dependent; and
 2. Primary to the plan covering the individual as other than a dependent (e.g., a retired employee),

then the order of benefits is reversed so that the plan covering the individual as an employee, member, subscriber, or retiree is secondary and the other plan is primary.

Rule 2: Dependent Child Covered Under More Than One Plan.

- A. The Plan that covers the parent whose birthday falls earlier in the calendar year pays first; and the Plan that covers the parent whose birthday falls later in the calendar year pays second, if:
 - 1. the parents are married or living together;
 - 2. the parents are not separated (whether or not they ever have been married); or
 - 3. a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.
- B. If both parents have the same birthday, the Plan that has covered one of the parents for a longer period of time pays first; and the Plan that covered the other parent for the shorter period of time pays second.
- C. The word “birthday” refers only to the month and day in a calendar year, not the year in which the person was born.
- D. If the specific terms of a court decree state that one parent is responsible for the child’s health care expenses or health care coverage, and the Plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child’s health care services or expenses, but that parent’s spouse does, the Plan of the spouse of the parent with financial responsibility pays first. This rule applies to plan years commencing after the Plan is given notice of the court decree.
- E. If the parents are divorced, separated or not living together (whether or not they have ever been married), and there is no court decree allocating responsibility for the child’s health care services or expenses, the order of benefit determination among the Plans of the parents and their spouses (if any) is:
 - 1. The Plan of the custodial parent pays first;
 - 2. The Plan of the spouse of the custodial parent pays second; and

3. The Plan of the non-custodial parents pays third; and
4. The Plan of the spouse of the non-custodial parent pays last.

If the dependent child is covered under a Plan of an individual other than the parents, the order of benefits is determined as if those individuals were the parents of the child. The custody rule is applicable to anyone who has legal custody of the dependent child.

Rule 3: Active/Laid-off or Retired Employee

- A. The Plan that covers a person as an active employee, that is, an employee who is neither laid-off or retired, is primary. The Plan covering that same person as a retired or laid-off employee is secondary. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee.
- B. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- C. This rule does not apply if Rule #1 described above can be used to determine the order of benefits

This rule is applicable only in the rare situations when the same individual is covered under two plans, one as an active employee and the other as a retired or laid-off employee. This rule does not apply to an individual covered under his or her own Plan as either an active, retired, or laid-off employee and also as a dependent under another Plan. In those situations, Rule #1 should be applied.

Rule 4: Continuation Coverage

- A. If a person whose coverage is provided under a right of continuation under federal or state law (e.g. COBRA) is also covered under another Plan, the Plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the Plan providing continuation coverage to that same person pays second.
- B. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

This rule is applicable only to the rare situations when an individual is covered under both COBRA and non-COBRA plans as other than a dependent, or as a dependent of an individual who is covered under both plans as a non-dependent. In the majority of continuation coverage situations, two employee spouses are involved (one on COBRA and one on the basis as active employment). In this scenario, Rule #1 is applicable.

Rule 5: Longer/Shorter Length of Coverage

If none of the four previous rules determines the order of benefits, the Plan that covered the person for the longer period of time pays first; and the Plan that covered the person for the shorter period of time pays second.

Rule 6: None of the Above Rules Apply

If the preceding rules do not apply, the allowable expenses shall be shared equally between the Plans.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any other plan, the plan may without the consent of or notice to any persons release to, or obtain from, any insurance company or other organization or person any information with respect to any person which it deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan information as may be necessary to implement this provision.

FACILITY OF PAYMENT

Whenever payments which should have been made under the Plan in accordance with this provision have been made under any other plan, the Plan shall have the right, exercisable alone and at its sole discretion, to pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision and amounts so paid shall be deemed to be benefits paid under this Plan and to the extent of such payments for covered services, the Plan shall be fully discharged from liability.

SECTION N

MEDICARE SELECTION PROVISION

If the Employer has **less** than 20 Employees in the current Calendar Year, Medicare coverage is primary (and this Plan will be secondary) for active Employees age 65 or older and their Dependents 65 or older. This Plan will reduce payment by the amount paid or payable by Medicare.

If the Employer had 20 or **more** Employees in the current or preceding Calendar Year, Federal law requires that Medicare coverage be secondary to this Plan. The Plan Member has the option of rejecting this Plan thereby retaining Medicare as his/her primary coverage. If the Plan Member chooses Medicare as primary, the Employer cannot provide any supplemental coverage. If the Plan Member rejects coverage under this Plan that choice must be made in writing to the Employer.

Federal law also mandates which plan is primary in the case of certain persons who are totally disabled or have end stage renal disease.

NOTE: This Plan will determine the primary and secondary payment of claims based on the current rules and regulations set forth by Medicare.

SECTION O

GENERAL PROVISIONS

The Plan and The Master Plan Document

The Plan Sponsor has filed the Master Plan Document in the office of the Human Resource Department, which can be inspected at any time during normal working hours by any Plan Member.

The Plan is a legal entity. Legal notices may be filed with, and legal process served upon, the Plan Administrator.

Plan Administrator

The Plan Administrator as used herein shall be the person or firm responsible for the day to day functions and management of the Plan. The Plan Administrator is the Employer.

The construction and interpretation of the Plan are vested with the Plan Administrator, in its absolute discretion, including, without limitation, the determination of benefits, eligibility and interpretation of Plan provisions. The Plan Administrator will endeavor to act, whether by general rules or by particular decisions, so as to treat all persons in similar circumstances without discrimination. All such decisions, determinations and interpretations shall be final, conclusive and binding upon all parties having an interest in the Plan.

Named Fiduciary

The Named Fiduciary is the Plan Administrator and has the authority to control and manage the operation and administration of the program. A participant under the Plan will not receive Plan benefits unless the Plan Administrator determines that the participant is entitled to such benefits.

Claims Administrator

The Claims Administrator will provide technical services in connection with operation of the coverage and performing other functions.

The Plan Is Not An Employment Contract

The Plan shall not be deemed to constitute a contract between the Employer and any Employee or be a consideration for, or an inducement or condition of, the employment of an Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provision of any collective bargaining agreements which may be made by the Employer with the bargaining representative of any Employees.

Exchange Of Information

The Plan will promptly provide to appropriate Federal, state and local law enforcement authorities and to other appropriate health plans:

1. Information indicating a potential violation of civil, criminal, or administrative laws relating to fraud and abuse with respect to health plans.
2. Information requested by Federal, state, or local law enforcement agencies which the agency states is relevant to an investigation, audit, evaluation, or inspection under the Federal Fraud and Abuse Control Program.
3. Information which would assist in the identification of potential violations or assist in the identification of areas requiring investigation, audit, evaluation, or inspection. Such information may include:
 - a. Surveys; Quality assurance reviews;
 - b. Provider and patient profiles;
 - c. Utilization review, and
 - d. Other similar analyses.

Alternative Treatment

The Plan Administrator has the right to approve coverage for treatment, procedures or facilities that are not normally covered under the Plan, if the Plan Administrator feels that this alternative treatment, procedure or facility offers a cost-effective method of treating the Plan Member's condition. Such approval in no way obligates the Plan Administrator to approve such coverage in the future, nor does it obligate the Plan

Administrator to approve of Alternative Treatment for any other Plan Member. Each case will be decided on its own merits.

Free Choice of Physician

Each Plan Member has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. The Plan Member, together with his Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The PPO providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any PPO provider.

Qualified Medical Child Support Orders (QMCSO)

The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a "Qualified Medical Child Support Order" ("QMCSO") if such an individual is not already covered by the Plan as an eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

"Alternate Recipient" shall mean any child of a Plan Member who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Plan Member's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Plan Member.

Upon receiving a Medical Child Support Order (Order), the Plan Administrator shall, as soon as administratively possible:

1. Notify the Plan Member and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and
2. Make an administrative determination if the Order is a QMCSO and notify the Plan Member and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice (Notice), the Plan Administrator shall:

1. Notify the state agency issuing the Notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:

- a. Whether the child is covered under the Plan; and
 - b. Either the Effective Date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator shall:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and
2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

A Plan Member may request at any time a copy of QMCSO procedures from the Plan without charge.

Other Service Plan Contracts

If any Plan Member is covered under more than one Plan, the coverage that would be provided under this Plan in the absence of this provision shall be reduced to the extent necessary so that the sum of such reduced coverage, together with the benefits, if any, that are paid or payable under such other Plan contract for health service shall not exceed the total charges for the health service.

Worker's Compensation Notice

The Plan is not in lieu of, is not in any way subject to, and does not affect any requirement for coverage by worker's compensation insurance.

Erroneous Payment Refund Provision

Covered Expenses are occasionally paid erroneously by the Plan (i.e., paid more than once; incorrectly paid under the Plan's terms, conditions, limitations or exclusions; or conditionally paid pending further review). An Employee, Dependent, or health care service provider receiving such an overpayment or erroneous payment shall, upon

discovery or notice thereof, return such payment to the Plan within 30 days of discovery or demand. Neither the Plan nor the Plan Administrator shall have any obligation to make any other payment of the bill prior to refund by the health care provider, Employee or Dependent. A health care provider may not apply an erroneous or duplicate payment to another bill balance or any other Dependent. The Plan Administrator shall have the exclusive right to choose who will repay it for an overpayment or erroneous payment (i.e., including but not limited to the Employee, Dependent, health care service provider or another health benefit plan). If the Plan elects to seek refund from the Employee or Dependent, recovery of the overpaid amount shall, at the Plan Administrator's option, be reimbursed in a lump-sum, time payments or deducted from future claims presented for processing.

Health care service providers accepting payment for services from the Plan, in consideration of such payments, further agree to submit claims for reimbursement in strict accord with their state's health care practice acts, ICD-10, or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator.

Any claims not paid in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur a pre-judgment interest rate of 1 ½% per month. The Plan shall be entitled to litigation costs and actual attorney fees in the event it becomes necessary to institute suit to recover duplicate or erroneous payments or payments of improperly billed charges.

Conformity With Applicable Law

This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document.

Clerical Error

Clerical errors, such as inaccurate transcription of premiums, Effective Dates, termination dates, or such as erroneous mailings, shall not change the rights or obligations of any party under the Plan and shall not operate to grant additional benefits to Plan Members.

Fraud

The following actions by any Plan Member, or a Plan Member's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for that Plan Member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Plan Member in the Plan;
2. Attempting to file a claim for a Plan Member for services which were not rendered or drugs or other items that were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

No Waiver

The failure of the Plan Administrator to strictly enforce any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Plan Administrator reserves the right to strictly enforce each and every provision of this Plan at any time regardless of the prior conduct of the Plan Administrator and regardless of the similarity of the circumstances or the number of prior occurrences.

Plan Contributions

The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed by each Plan Member.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be free to determine the manner and means of funding the Plan. The amount of the Plan Member's contribution will be determined from time to time by the Plan Administrator.

Booklets

The Plan Administrator has issued to each Employee an individual booklet, which summarizes the benefits to which the person is entitled, to whom benefits are payable, and the provisions of the Plan affecting the Plan Members. The booklet is intended to satisfy any requirements for a Summary Plan Description.

Entire Plan

The Plan including any amendments, the Schedule of Coverage, any other applicable schedules, the attached papers, the application of the Employer for any reinsurance policy, and the individual applications, if any, of the Employees and eligible Dependents, constitute the entire description of benefits between the parties and any statement made by the Employer or by any Employee shall not, in any way, change such benefits.

All statements made by the Employer or by a Plan Member shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this Plan or be used in defense of a claim unless they are contained in writing and signed by the Employer or by the Plan Member, as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such contest.

Plan Modification and Amendment

The City Manager of the Company shall be empowered to amend this Plan or any benefit under this Plan at any time by a written instrument signed by the City Manager. An increase or decrease in Plan benefits will become effective as of the date specified in the Plan or in an applicable amendment.

The Plan will furnish each Plan Member with a summary of any material reductions in covered services or benefits not later than 60 days after the effective date of such change.

Plan Termination

The City Manager of the Company may terminate the Plan at any time. Upon termination, the rights of the Plan Members to benefits are limited to claims Incurred and due up to the date of termination. Any termination of the Plan will be communicated to Plan Members.

Assignment

The Plan Member's benefit payments may not be assigned except by consent of the Company to other than suppliers of medical services.

Automatic Assignment

All medical expense benefits payable under this Plan shall be paid to the medical service provider, unless the claimant furnishes proof of payment of the medical expenses at the time the claim is filed with the Claims Administrator, in which case the benefits shall be paid to the claimant. The Plan is discharged from liability to the extent of such amounts paid to the claimant for Covered Expenses.

Physical Examination

The Plan at its own expense shall have the right and opportunity to examine any Plan Member, whose Injury or Sickness is the basis of a claim, as often as it may reasonably require while a claim is pending.

Disclosure Of Electronic Protected Health Information (“Electronic PHI”) To The Plan Sponsor For Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

1. Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI; and
4. Report to the Plan any Security Incident of which it becomes aware.

Any terms not otherwise defined shall have the meanings set forth in the Security Standards.

Privacy Standards

1. Disclosure of Summary Health Information to the Plan Sponsor.

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

“Summary Health Information” may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

2. Disclosure of Protected Health Information (“PHI”) to the Plan Sponsor for Plan Administration Purposes.

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

- a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);
- b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
- d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- e. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);
- f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

- g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
- h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);
- i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- j. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - i. The following Employees or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

 HR Department
 City Manager
 - ii. The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
 - iii. In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Document relating to use and disclosure of PHI, the Plan Sponsor shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

“Plan Administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan Administration” functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

3. Disclosure of Certain Enrollment Information to the Plan Sponsor.

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan.

4. Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage.

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

5. Other Disclosures and Uses of PHI.

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

SECTION P

SUBROGATION/RIGHT OF REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Members, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Member(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage"). Plan Member(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Plan Member(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Member(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Plan Member(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Plan Member shall be a trustee over those Plan assets.

In the event a Plan Member(s) settles, recovers, or is reimbursed by any Coverage, the Plan Member(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Member(s). If the Plan Member(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Member(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Member(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Plan Member(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Member(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Plan Member(s) fails to so pursue said rights and/or action.

If a Plan Member(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Member(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Plan Member is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Plan Member is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Plan Member(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Plan Member(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

the Plan Member(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Member's/Plan Members' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Member(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, without regard to whether the Plan Member(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Member's/Plan Members' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Plan Member are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Plan Member's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Plan Member is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Member(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Member(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, disease or disability.

Plan Member is a Trustee Over Plan Assets

Any Plan Member who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Plan Member understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Plan Member is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Member obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Plan Member disputes this obligation to the Plan under this section, the Plan Member or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Plan Member, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

If at the time of Injury, Sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Plan Member(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Member(s), such that the death of the Plan Member(s), or filing of bankruptcy by the Plan Member(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Plan Member(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Plan Member(s) and all others that benefit from such payment.

Obligations

It is the Plan Member's/Plan Members' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.

7. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Member may have against any responsible party or Coverage.
8. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
9. In circumstances where the Plan Member is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Member obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
10. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Plan Member over settlement funds is resolved.

If the Plan Member(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Plan Member(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Member(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Member's/Plan Members' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Plan Member and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Plan Member's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Plan Member(s) in an amount equivalent to any outstanding amounts owed by the Plan Member to the Plan. This provision applies even if the Plan Member has disbursed settlement funds.

Minor Status

In the event the Plan Member(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

SECTION Q

CLAIM/APPEAL PROCEDURES

The procedures outlined below must be followed by Plan Members ("claimants") to obtain payment of health benefits under this Plan.

All claims and questions regarding health claims should be directed to the Claims Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the claimant is entitled to them. The responsibility to process claims in accordance with the Master Plan Document and summary plan description may be delegated to the Claims Administrator; provided, however, that the Claims Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion. The Plan Administrator has retained the services of an independent third party administrator, EBSO, Inc. ("Claims Administrator") to provide technical services, including the processing of claims.

Each Plan Member claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator, in its sole discretion may require, written proof that the expenses were incurred and that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the claimant has not incurred a Covered Expense or that the benefit is not covered under the Plan, or if the claimant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

Under the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

Definitions

Words which are capitalized in this document are either defined below or in the Master Plan Document (see Definitions of General Terms, General Information and General Provisions) and summary plan description.

Pre-service Claims:

A "Pre-service Claim" arises when there is a claim for a benefit under the Plan and the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A "Pre-service Urgent Care Claim" arises when there is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant

or the claimant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

It is important to remember that, if a claimant needs medical care for a condition which could seriously jeopardize his life, there is no need to contact the Plan for prior approval. The claimant should obtain such care without delay.

Further, if the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Concurrent Claims:

A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the claimant requests extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Post-service Claims:

A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed

Health claims must be filed with the Claims Administrator within six months of the date charges for the service were incurred. However in no event, except in the absence of legal capacity, will claims be accepted later than 12 months from the date the charge in question was incurred. Charges are considered incurred when treatment or care is given or supplies are provided. **Claims filed later than that date shall be denied.**

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Utilization Review Organization in accordance with the Plan's Utilization Review procedures.

However, a Post-service Claim is considered to be filed when the following information is received by the Claims Administrator, together with a Form HCFA, Form UB92 or Form ADA:

1. The date of service;
2. The date the Injury or Sickness began;
3. The name, address, telephone number and tax identification number of the provider of the services or supplies;
4. The place where the services were rendered;
5. The diagnosis and procedure codes;
6. The amount of charges;
7. The name of the Plan and Plan ID #;
8. The name and home address of the Employee;
9. The Employee's social security number;
10. The name and home address of the patient; and
11. The patient's social security number.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Utilization Review Organization will determine if enough information has been submitted to enable proper consideration of the Pre-service Claim or Pre-service Urgent Claim. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the post-service claim. If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within 45 days (or by the Utilization Review Organization within 48 hours in the case of Pre-service Urgent Care Claims) from receipt by the claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

NOTE: The Plan does not consider inquiries about benefits, eligibility or the circumstances under which benefits might be paid, to be claims. An inquiry does not become a claim unless the proper claim procedure is followed. Further, questions concerning eligibility for benefits, such as calls from providers of medical services, are NOT ever considered claims.

Timing of Claim Decisions

The Plan Administrator shall notify the claimant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

Pre-service Urgent Care Claims:

If the claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim. The claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded the claimant to provide the information.

Pre-service Non-urgent Care Claims:

If the claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the claimant (if additional information was requested during the extension period).

Concurrent Claims:

Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The claimant will be notified sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving Urgent Care and decided within the Urgent Care timeframe.

Request by Claimant Involving Non-urgent Care. If the Plan Administrator receives a request from the claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

Post-service Claims:

If the claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If the claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the claimant will be notified of the determination by a date agreed to by the Plan Administrator and the claimant.

Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service Urgent Care Claims.

Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a claimant with a notice, either in writing or electronically (or, in the case of Pre-service Urgent Care Claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), containing the following information:

1. A reference to the specific portion(s) of the Master Plan Document and summary plan description upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the claimant's right to bring a civil action following an adverse benefit determination on final review;
5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;
6. The identity of any medical, dental or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the claimant, free of charge, upon request);
8. In the case of denials based upon a medical judgment (such as whether the treatment is Medical Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided to the claimant, free of charge, upon request; and
9. In a claim involving Urgent Care, a description of the Plan's expedited review process.

Requested copies will be provided to the claimant within a reasonable period of time, not to exceed 30 days from the date the Plan receives the written request for copies.

Appeal of Adverse Benefit Determinations – Internal Review

A. Procedures for Review of Adverse Benefit Determinations

In cases where a claim for benefits is denied, in whole or in part, and the claimant believes the claim has been denied wrongly, the claimant may appeal the denial and review relevant documents. The claims procedures of this Plan provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. Claimants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination. If the claimant does not appeal on time, he/she will lose the right to file suit in court and will have failed to exhaust the Plan's internal administrative appeal procedures, which is generally a prerequisite to bringing suit;
2. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. For a review that is independent from the initial adverse benefit determination and is conducted by an appropriate named fiduciary of the Plan who is not the same individual who decided the claimant's initial adverse benefit determination and who is not also that individual's subordinate;
4. For a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
5. That, if an adverse benefit determination is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with an independent health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is not the same person as the health care professional consulted in connection with the initial adverse benefit determination;
6. For the identity of medical/vocational experts consulted in connection with the appeal, even if the Plan did not rely upon their advice; and
7. In an Urgent Care Claim, for an expedited review process pursuant to which:
 - a. A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

- b. All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

B. Requirements for Appeal

The claimant must file the appeal in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) within 180 days following receipt of the notice of an initial adverse benefit determination. For Pre-service Urgent Care Claims, if the claimant chooses to orally appeal, claimant may telephone: Appeal Dept. EBSO, Inc. at 800-558-7798. To file an appeal in writing, the claimant's appeal must be addressed as follows and mailed and/or faxed to the following number: *Attention: Appeal Dept. c/o EBSO, Inc. 215 Stanford Parkway, Findlay, OH 45840. Fax (419) 423-5834.*

It shall be the responsibility of the claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee;
2. The name of the claimant;
3. The Employee's social security number;
4. The claimant's social security number;
5. The group name and identification number;
6. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories which support this claim if the claimant fails to include them in the appeal;**
7. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
8. Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.

If the claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

C. Notification of Benefit Determination on Review

The Plan Administrator shall notify the claimant of the Plan's benefit determination on review within the following timeframes:

Pre-service Urgent Care Claims: As soon as possible, taking into account the medical

exigencies, but not later than 72 hours after receipt of the appeal.

Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – Pre-service Urgent, Pre-service Non-urgent or Post-service.

Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

D. Manner and Content of Notification of Adverse Benefit Determination on Review.

The Plan Administrator shall provide a claimant with notification, with respect to Pre-service Urgent Care Claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Master Plan Document and summary plan description on which the denial is based;
3. The identity of any medical, dental or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided free of charge upon request;

7. A description of any available External Review process and how to initiate an External Review;
8. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office or the Plan Administrator."

If, for any reason, the claimant does not receive a written response to the appeal within the appropriate time period set forth above, the claimant may assume that the appeal has been denied and the Plan's internal review procedures have been exhausted.

Appeal of Adverse Benefit Determinations – External Review

A. Overview

If the claim is denied, the claimant may be eligible to have his/her claim reviewed by an Independent Review Organization (IRO) pursuant to a process called "External Review." Generally, External Review is available only after the claim denial has been upheld after the final level of appeal under the Plan. The claimant may, however, in limited circumstances have the right to have the claim reviewed by an IRO prior to exhausting the Plan's appeal process. See **Expedited External Review** for further details.

B. Request for Review

External Review is available only for medical claims (excluding dental and vision) that involve medical judgment (including, for example, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination as to whether a treatment is experimental or investigational) and for rescissions of coverage (i.e. retroactive cancellations of coverage because of the Plan Member's fraud or intentional misrepresentation of a material fact regarding eligibility for coverage).

Federal government agency guidance may further limit or broaden the scope of External Review. The Plan will provide an External Review process in accordance with applicable guidance.

A request for External Review must be filed in accordance with the instructions contained in the claimant's appeal denial notice and must be received not later than four months after the date he/she receives the appeal denial notice. If there is no corresponding date four months after the date of the appeal denial notice, then the request must be filed by the first day of the fifth month following receipt of the notice. For example, if the date of the denial notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

C. Preliminary Review

Within five business days after receiving the claimant's External Review request, the Plan Administrator will complete a preliminary review to determine whether his/her request is complete and eligible for External Review. That preliminary review will determine: whether the claimant was covered under the Plan at the time the item or service was requested or provided; whether the final denial of his/her appeal related to the claimant's failure to meet the Plan's eligibility requirements; whether the claimant exhausted the Plan's internal appeal process (or are not required to exhaust the process); and whether the claimant has provided all the information and forms required to process an External Review.

Within one business day after the completion of the preliminary review, the Plan Administrator will notify the claimant of one of the following:

1. That his/her request is complete, but she/he is not eligible for external review. This notice will state the reasons for the ineligibility and provide contact information for the Employee Benefits Security Administration.
2. That his/her request is incomplete, but may still be eligible for external review. This notice will describe the information or materials needed to complete the request. The claimant will be permitted to provide the required information by the later of: (a) the last day of the four month filing period or (b) 48-hours after receipt of the notice.
3. That his/her request is complete and eligible for external review.

D. Referral to IRO

If the claimant's request for External Review is complete and eligible, the Plan Administrator will assign a qualified IRO to conduct the External Review and within five business days after making the assignment will provide the IRO with the documents and information the Plan Administrator considered in making its final appeal denial.

The claimant will have at least 10 days to submit additional information to the IRO. If the claimant submits additional information, the IRO will send that information to the Plan and the Plan may reconsider its determination. If the Plan decides, on reconsideration, to reverse its benefits denial and provide coverage or payment, then the external review can be terminated.

If the Plan does not reverse its determination, the IRO will review all of the information and documents timely received. In reaching a decision the IRO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeal process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate will

consider the following in reaching a decision: the claimant's medical records; the attending health care professional's recommendation; reports from the appropriate health care professionals and other documents submitted by the Plan Administrator, the claimant's treating provider; the terms of the Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan; appropriate practice guidelines; any applicable clinical review criteria developed and used by the Plan; and the opinion of the IRO's clinical reviewer(s).

The IRO must provide written notice to the claimant and the Plan Administrator of the final External Review decision within 45 days after the IRO receives the request for External Review. If the IRO reverses the Plan's determination, the Plan must immediately provide coverage or payment for the claim.

E. Expedited External Review

Under the following circumstances, the claimant may be eligible to file for an expedited External Review:

1. If the claimant receives a claim denial that involves a medical condition for which the timeframe for completion of an expedited internal appeal with the Plan Administrator would seriously jeopardize the claimant's life or health, or that would jeopardize the claimant's ability to regain maximum function, and the claimant has filed a request for an expedited internal appeal; or
2. If the claimant receives a final appeal denial from the Plan Administrator and: he/she has a medical condition for which the timeframe for completion of a standard external appeal would seriously jeopardize his/her life or health, or would jeopardize his/her ability to regain maximum function; or if the final claim denial concerns an admission, availability of care, continued stay, or health care item or service for which the claimant has received emergency services but have not been discharged from a facility.

Immediately upon receipt of the request for an expedited External Review, the Plan Administrator will complete a preliminary review of the claimant's request in order to determine his/her eligibility for expedited External Review. Immediately after completion of the preliminary review, the Plan Administrator will issue the claimant a written notification of his/her eligibility for expedited External Review. If the claimant's request is complete but not eligible for External Review, the notice will include the reasons for ineligibility. If the claimant's request is incomplete, the notice will describe the information or materials needed to make the request complete and the claimant will have an opportunity to complete the request.

Upon a determination that a request is eligible for expedited External Review, the Plan Administrator will assign an IRO for review and transmit all necessary documents and

information to the IRO. The IRO must provide notice, to the claimant and the Plan Administrator of the final External Review decision as expeditiously as possible, but in no event later than 72 hours after the IRO receives the request for the expedited External Review.

All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.

Appointment of Authorized Representative

A claimant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the claimant must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. **In the event a claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the claimant, unless the claimant directs the Plan Administrator, in writing, to the contrary.**

MASTER PLAN DOCUMENT AMENDMENT #1

Effective July 1, 2019, the Master Plan Document and Summary Plan Description for City of San Luis is hereby amended as follows:

SCHEDULE OF COVERAGE, is hereby deleted and replaced with Attachment A

DEFINITIONS OF GENERAL TERMS, EMPLOYEE, is hereby deleted replaced with the following:

EMPLOYEE means an Employee of the Employer who is regularly scheduled to actively perform the principle duties of his/her occupation a minimum of 30 hours per week, and who is enrolled and eligible for coverage under the Plan. Employee also includes Council Members who are working a minimum of 20 hours per month.

Part-time, seasonal, temporary and retired employees are not eligible for coverage under the Plan. Employee does not include the following:

1. a self-employed individual as described in Section 401 (c) of the Code, including, but not limited to, a sole proprietor if the Employer is a sole proprietorship, a person owning more than 2% of the Employer if it is a Subchapter S corporation, a partner of the Employer if it is a partnership, and a member of the Employer if it is a limited liability company and the members are treated as partners for income tax purposes;
2. an employee who is a spouse, child, grandchild, or parent of a person owning more than 2% of the Employer if it is a Subchapter S corporation;
3. any individual included within a unit of employees covered by a collective bargaining unit unless such agreement expressly provides for coverage of the Employee under the Plan;
4. any individual who is a nonresident alien and receives no earned income from the Employer from sources within the United States;
5. any individual who is a leased employee as defined in Section 414(n)(2) of the Code;
6. any individual who performs services for the Employer through, and is paid by, a third-party (including but not limited to an employee leasing or staffing agency) even if such individual is subsequently determined to be a common law employee of the Employer; or
7. any individual who performs services for the Employer pursuant to a contract or agreement (whether verbal or written) which provides that such individual is an independent contractor or consultant, even if such individual is subsequently determined to be a common law employee of the Employer.

PRE-CERTIFICATION, is hereby deleted and replaced with the following:

PRE-CERTIFICATION

PRE-CERTIFICATION IS REQUIRED FOR THE FOLLOWING SERVICES:

- All non-Emergency Hospitalizations (including skilled nursing facility, inpatient rehabilitation and residential treatment facilities)
- Outpatient surgery
- Hospice
- Home Health Care
- Durable Medical Equipment > \$750 or when rental exceeds 4 months
- Inpatient Rehabilitation/Habilitation services

FOR PRE-CERTIFICATION CALL EBSO-REVIEW, AT 1-800-426-9317. Non-compliance reduces benefits. If a Plan Member does not comply with Pre-certification when required, Covered Expenses will be reduced by a penalty of
PPO: \$500 per service or
Non-PPO: 50% of the total cost of the service.

This reduction is in addition to the Deductible.

Please be prepared to supply the following basic information:

1. Patient's name and date of birth
2. Employee's name, address and phone number
3. Physician's name and phone number
4. Name of the Hospital
5. Reason for the hospitalization
6. Date the hospitalization started
7. Employer's I.D. Number.

The following is hereby added:

INCENTIVE PROGRAM FOR PPO PROVIDER SELECTED HOSPITAL/OUTPATIENT FACILITY AKA WIN/WIN INCENTIVE PROGRAM

The Plan receives greater discounts through the *PPO* Provider Selected Hospital and Outpatient Facility listing below.

As an incentive to use one of the exclusive provider Hospitals and Outpatient facilities listed below, when a Plan Member utilizes one of the exclusive provider Hospitals or Outpatient facilities, the Plan will issue a check to the Employee the

amount of the reimbursement applied to that Covered Expense.

This benefit is subject to the procedure or confinement being a Covered Expense under this Plan. This incentive program applies to the Employee and covered Dependents. The incentive payment shall be issued in the name of the Employee.

The incentive payment will be issued upon the claims administrator's receipt of the claim for the Covered Expense.

INCENTIVE PROGRAM PLAN

Reimbursement for Incentive Program	
Inpatient - Lodging Reimbursement	Up to \$125 per night for up to 4 nights
Outpatient - Lodging Reimbursement	Up to \$125 per night for up to 4 nights
Maximum Out of Pocket (In Network)	\$5,500 + Lodging reimbursements
Hospitalizations for Incentive Program	
Hospitalization and Outpatient	0% + Deductible
	Plan Member Pays
X-rays and Labs	
At Primary Care Provider - Diagnostic, X-ray and Lab	\$15 Copay
At Specialty Care Provider - Diagnostic, X-ray and Lab	\$25 Copay
At Contracted Stand-Alone Provider i.e. Focus Imaging, Sonora Quest and Lab Corp	\$15 Copay
At a Hospital -	20% + Deductible
Complex Imaging – MRI, CT, PET Scan	
At Contracted Stand-Alone Provider i.e. Focus Imaging, Sonora Quest and Lab Corp	\$25 Copay
At a Hospital - Complex, MRI, CT and Pet Scan	20% + Deductible

PPO Provider Selected Hospital and Outpatient Facility list shall include the following providers:

Desert Ridge Outpatient Surgery Center

20940 N Tatum Blvd #370
PHX 85050
480-502-4010

Metro Surgery Center

6790 W. Thunderbird Rd
Peoria, AZ 85381
623-979-1717

Oasis Hospital

750 N 40th St.
PHX 85008

Canyon Surgery Center

6036 N 19TH Ave #100
PHX 85015

AZ Outpatient Surgery Center

6245 N 16TH St
PHX 85016

The Surgical Hospital of PHX

6501 N 19TH Ave
PHX 85015

Banner Estrella Surgery Center

9301W Thomas Rd
Phoenix, AZ 85037
(623) 388-5700

Phoenix Orthopedic Ambulatory

690 N Cofco Center Ct Ste 150
Phoenix, AZ 85008
(602) 288-4476

Outpatient Surgical Care

1530 W Glendale Ave Ste105
Phoenix, AZ 85021
(602) 995-3395

Peoria Surgery Center

13260 North 94th Drive Suite 200
Peoria, Arizona 85381
Phone: (623) 933-2900

Northwest Tucson Surgery Center AKA Northwest Hospital

(520) 877-6700
6320 N. La Challa Blvd., Suite 100
Tucson, AZ 85741

Oro Valley Hospital

(520) 901-3500
1551E. Tangerine Road
Oro Valley, AZ 85755

Carondelet Foothills Surgery Center

(520) 877-5660

2220 W. Orange Grove Road
Tucson, AZ 85741

Accepted By:

Name:	Title	Date
For: City of San Luis		

SCHEDULE OF COVERAGE

NOTE: THIS IS ONLY A SUMMARY, SPECIFIC SERVICES AND SUPPLIES MAY BE SUBJECT TO OTHER DEDUCTIBLES, COPAYS, PAYMENT PERCENTAGES, MAXIMUM BENEFIT PAYMENTS, AND/OR EXCLUSIONS AND LIMITATIONS.

NOTE: Benefits under this Plan will be paid only if the Plan Administrator decides in his/her discretion that the individual is entitled to them.

COMPREHENSIVE MAJOR MEDICAL PLAN:

DEDUCTIBLE PER COVERAGE YEAR

PPO:	\$750 INDIVIDUAL	NON-PPO:	\$1,500 INDIVIDUAL
	\$1,500 FAMILY		\$3,000 FAMILY

The PPO Deductible and the Non-PPO Deductible shall accumulate independently and shall not be used to satisfy each other.

The family Deductible is the amount contributed toward the Deductible by two or more family members; provided, the amount contributed toward the family Deductible by any one family member cannot be more than the individual Deductible amount.

ANNUAL OUT-OF-POCKET MAXIMUM PER COVERAGE YEAR

PPO:	\$5,500 INDIVIDUAL	NON-PPO:	\$20,000 INDIVIDUAL
	\$11,000 FAMILY		\$40,000 FAMILY

The PPO Annual Out-of-pocket Maximum and the Non-PPO Annual Out-of-pocket Maximum shall accumulate independently and shall not be used to satisfy each other.

The family Annual Out-of-pocket is the amount contributed toward the Annual Out-of-pocket by two or more family members; provided, the amount contributed toward the family Annual Out-of-pocket by any one family member cannot be more than the individual Annual Out-of-pocket amount.

The Annual Out-of-pocket Maximum **includes** the Deductible, Coinsurance, and Copays. The Annual Out-of-pocket Maximum does **NOT** include any charge in excess of the established plan maximums/limitations and penalties for non-compliance with Plan provisions.

COVERAGE YEAR MAXIMUM PAYMENT AMOUNT	Unlimited

PRE-CERTIFICATION IS REQUIRED FOR THE FOLLOWING SERVICES:

- All non-Emergency Hospitalizations (including skilled nursing facility, inpatient rehabilitation and residential treatment facilities)
- Outpatient surgery
- Hospice
- Home Health Care
- Durable Medical Equipment > \$750 or when rental exceeds 4 months
- Inpatient Rehabilitation/Habilitation services

FOR PRE-CERTIFICATION CALL EBSO-REVIEW, AT 1-800-426-9317. Non-compliance reduces benefits. If a Plan Member does not comply with Pre-certification when required, Covered Expenses will be reduced by a penalty of

PPO: \$500 per service or

Non-PPO: 50% of the total cost of the service.

This reduction is in addition to the Deductible.

THE PPO IS ADMINISTERED BY:	BCBS of Arizona
	Multiplan wrap
	In Mexico, SIARMED

The Plan will at all times be in compliance with PPACA rules and regulations. PPACA requires that benefits that are offered by the Plan that are “Essential Health Benefits” as defined by the United States Department of Health And Human Services may not be restricted to less than a certain annual amount. If a major medical benefit of the Plan has a plan maximum below that amount, the Plan will continue to pay benefits for the Essential Health Benefit components of that benefit even though such payments would exceed the plan maximum for that benefit, but only until the Coverage Year Maximum Payment Amount of the Plan is paid.

This plan may provide a greater discounts / reimbursement for services received through the PPO Provider Selected Hospital and Outpatient Facility. Refer to the **INCENTIVE PROGRAM FOR PPO PROVIDER SELECTED HOSPITAL/OUTPATIENT FACILITY AKA WIN/WIN INCENTIVE PROGRAM** for more information and a list of providers.

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Acupuncture	80% after Deductible	60% after Deductible	LIMITED to a maximum of 26 visits per Coverage Year.
Ambulance Services -Air and Ground	80% after Deductible	80% after Deductible	
Amino acid-based formula	25% after Deductible	25% after Deductible	LIMITED to supplies not covered under the Prescription Drug Card Benefit. The maximum annual benefit for amino acid based formula to treat eosinophilic gastrointestinal disorder is \$20,000 per Plan Member per Coverage Year.
Chiropractic Care	100% after a \$15 Copay per visit (Deductible waived)	60% after Deductible	Includes x-rays, manipulations, supportive care, and maintenance care. LIMITED to a maximum of 20 visits per Coverage Year.
Dental Hospitalization and Dental Services Office Visits	80% after Deductible	60% after Deductible	Diagnostic procedures & treatment of TMJ are LIMITED to a Lifetime maximum benefit payment of \$300.
Durable Medical Equipment, Prosthetics, Orthotics and Disposable Supplies	80% after Deductible	60% after Deductible	Hearing aids are LIMITED to one per Coverage Year.
Emergency Services and Urgent Care Services			In an Emergency, as defined by the Plan, Non-PPO Covered Expenses will be paid at the PPO level.
Emergency visit	80% (Deductible waived).	80% (Deductible waived).	
Urgent Care	100% after a \$30 Copay per visit (Deductible waived)	60% after Deductible	

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Home Health Care	80% after Deductible	60% after Deductible	LIMITED to a maximum of 60 visits per Coverage Year.
Hospice Care	80% after Deductible	60% after Deductible	Bereavement Counseling is LIMITED to a Lifetime maximum benefit payment of \$300 per family.
Inpatient Hospital Services (Non-Emergency), Outpatient Hospital, or Ambulatory Surgical Center Services			
At Selected PPO providers	100% after Deductible	60% after Deductible	
All others	80% after Deductible	60% after Deductible	
Inpatient and Outpatient Physician Services			
Primary Care Physician Office Visits (includes lab and X-ray)	100% after a \$15 Copay per visit (Deductible waived)	60% after Deductible	
Specialist Office Visits (includes lab and X-ray)	100% after a \$25 Copay per visit (Deductible waived)	60% after Deductible	
Inpatient Visit	100% after a \$15 Copay per visit (Deductible waived)	60% after Deductible	
Surgery (Physician's office)	100% after a \$15 Copay per visit (Deductible waived)	60% after Deductible	
Surgery (other)	80% after Deductible	60% after Deductible	
Physician Services – Pathology, Anesthesiology, or Radiology	80% after Deductible	60% after Deductible	
Maternity			
Prenatal visits	100% (Deductible and Copays waived)	60% after Deductible	
Hospital Services	80% after Deductible	60% after Deductible	

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Medical Foods	50% after Deductible	Not covered except in an Emergency. In an Emergency, covered expenses will be paid at PPO level.	LIMITED to supplies not covered under the Prescription Drug Card Benefit. The maximum annual benefit for medical food to treat an Inherited Metabolic Disorder is \$5,000 per Plan Member per Coverage Year.
Mental/Nervous Disorders and/or Substance Abuse			
Inpatient treatment	80% after Deductible	60% after Deductible	
Outpatient treatment	100% after a \$15 Copay per visit (Deductible waived)	60% after Deductible	
Outpatient Diagnostic Tests			
Complex - MRI, CT, PET Scans			
At contracted Stand-Alone provider(i.e. Sonora Quest, Lab Corp, Focus Imaging)	100% after a \$25 Copay per visit (Deductible waived)	60% after Deductible	
Other providers:	80% after Deductible	60% after Deductible	
Other X-rays and Laboratory tests – Contracted Stand-Alone Provider (i.e. Sonora Quest, Lab Corp)	100% after a \$15 Copay per visit (Deductible waived)	60% after Deductible	
Other X-rays and Laboratory tests – primary care	100% after a \$15 Copay per visit (Deductible waived)	60% after Deductible	
Other X-rays and Laboratory tests – Specialist care	100% after a \$25 Copay per visit (Deductible waived)	60% after Deductible	

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Preventive Care Services Pediatric and Adult Preventive Care Immunizations, inoculations, vaccinations Sterilization – limited to Employee and covered Spouse only	100% (Deductible waived) 100% (Deductible waived) 100% (Deductible waived)	80% after Deductible 100% after a \$20 Copay per visit (Deductible waived) 80% after Deductible	Refer to benefit section for more information on Preventive Services. Includes prescription contraceptives, unless covered under the Prescription Drug Card Benefit. Cost sharing will apply to a brand name contraceptive if a generic version is available and just as effective and safe.
Rehabilitation and Habilitation Services Physical, Speech, Occupational Therapy All Other	100% after a \$30 Copay per visit (Deductible waived) 80% after Deductible	60% after Deductible 60% after Deductible	Physical, Occupational and Speech therapy are LIMITED to a maximum of 60 Outpatient visits per Coverage Year, combined.
Skilled Nursing Facility	80% after Deductible	60% after Deductible	LIMITED to a maximum of 90 days per Coverage Year.
Therapy services – Chemotherapy, Dialysis, Radiology	80% after Deductible	60% after Deductible	
Transplants			
Hospitalization	80% after Deductible	60% after Deductible	
Associated Office Visits	100% after a \$15 Copay per visit (Deductible waived)	60% after Deductible	
All other Covered Expenses	80% after Deductible	60% after Deductible	

PRESCRIPTION DRUG CARD EXPENSE BENEFIT

NOTE: Copays may not apply to certain preventive prescription and over-the-counter medications. Contact the Prescription Drug Card Administrator for more information. Note: the brand name copay will apply to a brand name contraceptive if a generic version is available and just as effective and safe.

Prescriptions must be obtained through Magellan Rx, except in an emergency. Prior authorization is required for some prescription drugs.

Retail (30 day supply)

Formulary Generic/Diabetes syringes or lancets	\$5 Copay
Formulary Brand	\$35 Copay
Non-Formulary Brand	\$55 Copay
Diabetic insulin (2 vials) or test strips	\$25 Copay

Magellan Rx Mail Service Program (90 day supply)

Formulary Generic/Diabetes syringes or lancets	\$15 Copay
Formulary Brand	\$75 Copay
Non-Formulary Brand	\$135 Copay
Diabetic insulin (6 vials) or test strips	\$75 Copay

THE PRESCRIPTION DRUG CARD EXPENSE BENEFIT IS ADMINISTERED BY: Magellan Rx

**City of San Luis
EMPLOYEE BENEFIT TRUST DENTAL BENEFIT PLAN**

**PLAN DOCUMENT and
SUMMARY PLAN DESCRIPTION**

EBSO GROUP NUMBER: SLS0001

Effective: July 1, 2018

TABLE OF CONTENTS

SECTION A	2
INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION	2
<i>Introduction and Purpose</i>	2
<i>General Plan Information</i>	3
SECTION B	5
SCHEDULE OF COVERAGE	5
SECTION C	6
DEFINITIONS OF GENERAL TERMS.....	6
SECTION D	15
ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE	15
EMPLOYEE ELIGIBILITY DATE	15
EMPLOYEE EFFECTIVE DATE OF COVERAGE	15
DEPENDENT ELIGIBILITY DATE	15
DEPENDENT EFFECTIVE DATE OF COVERAGE	16
CHANGE IN STATUS	16
SPECIAL ENROLLMENT PERIOD.....	17
OPEN ENROLLMENT PERIOD	18
CHOOSING PLAN OPTIONS.....	19
TERMINATION OF INDIVIDUAL COVERAGE.....	19
SECTION E.....	22
CONTINUATION OF COVERAGE UPON INDIVIDUAL TERMINATION (COBRA).....	22
SECTION F	35
UNIFORMED SERVICES CONTINUATION AND REINSTATEMENT PROVISION	35
SECTION G	37
GENERAL LIMITATIONS AND EXCLUSIONS	37
SECTION H	40
DENTAL BENEFITS	40
<i>Covered Dental Expenses</i>	40
SECTION I.....	42
CARE PROVIDED BY THE UNITED STATES GOVERNMENT	42
COORDINATION OF BENEFITS	42
EFFECT ON BENEFITS	43
SECTION J	47
MEDICARE SELECTION PROVISION	47
SECTION K	48
GENERAL PROVISIONS.....	48
<i>The Plan and The Master Plan Document</i>	48
<i>Plan Administrator</i>	48
<i>Named Fiduciary</i>	48
<i>Claims Administrator</i>	48
<i>The Plan Is Not A Contract</i>	49

<i>Exchange Of Information</i>	49
<i>Alternative Treatment</i>	49
<i>Free Choice of Physician</i>	50
<i>Qualified Medical Child Support Orders (QMCSO)</i>	50
<i>Other Service Plan Contracts</i>	51
<i>Worker’s Compensation Notice</i>	51
<i>Erroneous Payment Refund Provision</i>	51
<i>Conformity With Applicable Law</i>	52
<i>Clerical Error</i>	52
<i>Fraud</i>	53
<i>No Waiver</i>	53
<i>Plan Contributions</i>	53
<i>Plan Modification and Amendment</i>	54
<i>Automatic Assignment</i>	55
<i>Physical Examination</i>	55
<i>Disclosure Of Electronic Protected Health Information (“Electronic PHI”) To The Plan Sponsor For Plan Administration Functions</i>	55
<i>Privacy Standards</i>	55
SECTION L	59
SUBROGATION/RIGHT OF REIMBURSEMENT	59
SECTION M	66
CLAIM/APPEAL PROCEDURES	66

ESTABLISHMENT OF THE MASTER PLAN DOCUMENT

Effective July 1, 2018, the Plan Sponsor establishes City of San Luis Employee Benefit Trust Dental Benefit Plan (the "Plan") to provide self-funded benefits for its Employees and their Dependents.

This Plan replaces the Plan Sponsor's previous plan of dental benefits. It is the intent of the Plan Sponsor to provide continuous eligibility and coverage from the previous plan to this Plan.

The Plan Sponsor hereby adopts this Plan Document as the written description of the Plan.

Disclaimer Of Claims Administrator

EBSO, Inc. has prepared this document for your review and consideration; however, we are not legal counsel, nor are we in the business of practicing law. As your Plan's fiduciary, you are fully responsible for all legal issues that concern the Plan. If you are not an expert in this area, we urge you to hire an attorney to help you review this Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Date

Signature

Print or Type Name and Title

Witness Signature

Print or Type Witness Name

SECTION A

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

City of San Luis, the Employer, has established the City of San Luis Employee Benefit Trust Dental Benefit Plan in order to provide comprehensive dental benefits for Employees, and their Dependents.

The City of San Luis Employee Benefit Trust Dental Benefit Plan is a self-insured public sector plan within the meaning of Arizona Statute 11-981 (hereinafter “Plan”). The Dental Plan is not an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). Any resemblance to an ERISA plan shall not be construed to mean it is an ERISA plan. The Dental Plan is a self-insured medical plan intended to meet the requirements under Sections 105(b), 105(h) and 106 of the Internal Revenue Code of 1986 so the portion of the cost for coverage paid by the Employer is not taxable income to the Employee and any benefits received through the Dental Plan are not taxable income to the Employee. This Dental Plan is a group health plan for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and shall be administered in a manner consistent with HIPAA.

The Plan Sponsor has established the Plan for the benefit of eligible employees and their eligible dependents, on the terms and conditions described herein. The Plan Sponsor’s purpose in establishing the Plan is to help to offset, for eligible Employees, the economic effects arising from a non-occupational Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

This Plan is a non-grandfathered plan under Patient Protection and Affordable Care Act (PPACA) and Health Care and Education Reconciliation Act (HCERA), collectively referred to as Health Care Reform.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain medical expenses. The Plan Document is maintained by the Plan Sponsor and may be inspected at any time during normal working hours by any Plan Member.

The Schedule of Coverage is meant only as a summary of benefits. For more details about the benefits, check the Table of Contents and refer to the specific section in the booklet for complete terms and conditions.

This Plan covers only those expenses incurred in connection with non-occupational injuries or disease.

The Employer has contracted with the Claims Administrator to perform certain consultative and management services related to the Plan. The Employer retains ultimate authority for the Plan.

Certain words in this Plan have precise meanings and will be capitalized and defined in the Definition section or where used in the text, so that you will pay special attention to them.

New Rescission of Coverage Rules. Under this Dental Plan, coverage may be retroactively cancelled or terminated if you act fraudulently or make material misrepresentations of fact. It is your responsibility to provide accurate information and to make accurate and truthful statements including information and statements regarding familial status, age, relationships, etc. In addition, it is your responsibility to update previously provided information and statements. Failure to do so may result in your coverage, including the coverage of those provided coverage through you, being cancelled and such cancellation may be retroactive.

General Plan Information

Name of Plan:	City of San Luis Employee Benefit Trust Dental Plan
Plan Sponsor:	City of San Luis 1090 E. Union Street San Luis, AZ 85349 928-341-8547
Plan Administrator: (Named Fiduciary)	City of San Luis 1090 E. Union Street San Luis, AZ 85349 928-341-8547
Plan Sponsor ID No. (EIN):	86-0376164
Fiscal Year:	January 1 through December
Plan Number:	501
EBSO Group Number:	SLS001
Type of Administration:	Self-funded Dental Plan

Sources and Methods of
Contributions to the Plan:

The Employer and the Employee share in the cost of the Plan. The Employer's contribution is made from his general assets and the Employee's contribution is made from payroll deductions. The Employer will provide a schedule of the applicable premiums during the initial enrollment, during open enrollment periods, on the Plan's annual renewal date and upon request.

All contributions shall be held in the Trust.

The Plan is "self-insured" which means that benefits are paid with assets from the Trust established by the Employer to pay benefits under the Dental Plan.

Name of Trust

City of San Luis Employee Benefit Trust

Trustees

For current information on Trustees, please refer to the Agreement and Declaration of Trust for City of San Luis Employee Benefit Trust

Claims Administrator:

EBSO, Inc.
215 Stanford Pkwy
Findlay, OH 45840
Phone Number 800-558-7798

Please Note: EBSO, Inc. performs claims processing services pursuant to a contract, it does not insure benefits under the Dental Plan.

Agent for Legal Services:

City of San Luis
1090 E. Union Street
San Luis, AZ 85349
928-341-8547

SECTION B SCHEDULE OF COVERAGE

NOTE: THIS IS ONLY A SUMMARY, SPECIFIC SERVICES AND SUPPLIES MAY BE SUBJECT TO OTHER DEDUCTIBLES, COPAYS, PAYMENT PERCENTAGES, MAXIMUM BENEFIT PAYMENTS, USUAL, CUSTOMARY AND REASONABLE FEES AND/OR EXCLUSIONS AND LIMITATIONS.

NOTE: Benefits under this Plan will be paid only if the Plan Administrator decides in his/her discretion that the individual is entitled to them.

DENTAL BENEFITS

Calendar Year Deductible	
Class I Services	NONE
Class II, III and IV Services	
Individual	\$25
Family	\$50
Payment Percentages after Deductible is met	
Class I Services – Diagnostic and Preventive Care	100%
Class II Services - Basic Services	80%
Class III Services - Major Services	50%
Class IV Services – Orthodontics	50%
Maximum Benefits	
Per Calendar Year for Class I, II & III Services, combined	\$2,000
Per Lifetime for Class IV Services	\$2,000

If Covered Services are rendered in Mexico and in the United States in one Calendar Year, the Maximum Calendar Year benefit paid by the Dental Plan is \$2,000. Only \$1,000 of the Covered Services can be rendered in Mexico in the Calendar Year, and a Preferred Network Provider must be utilized for those Covered Services provided in Mexico.

If Orthodontia treatments that are Covered Services have started in Mexico, the treatment must be completed in Mexico. Orthodontia treatment completed in the United States will not be a Covered Service if the treatment started in Mexico.

NOTE: Orthodontic Services are **LIMITED** to Dependent children less than 19 years of age. Dependent children must be covered under the Plan for 12 consecutive months before orthodontic services are available.

SECTION C

DEFINITIONS OF GENERAL TERMS

When used and capitalized in this document, these terms have the following definitions. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of the Plan Document for that information.**

ALLOWED CHARGE means the maximum dollar amount eligible for payment for a procedure or service as determined by the Plan. This includes billed charges, contracted amounts or Usual, Customary and Responsible Fees, depending on the Dental Provider's relationship with the Plan and/or the dental services provided.

CALENDAR YEAR means the period from January 1 through the following December 31.

CALENDAR YEAR MAXIMUM BENEFIT means the total dollar amount of Covered Expenses a Plan Member may receive during a Calendar Year while enrolled under this Dental Plan. The Maximum Calendar Year Benefit does not include amounts which are the Plan Member's responsibility.

COINSURANCE means the charge a Plan Member must pay for certain Covered Services until the Calendar Year Maximum Benefit has been reached. Covered Services subject to Coinsurance and the amounts are listed in the Schedule of Coverage. Coinsurance is a percentage of the Allowed Charge. In some instances, the Plan Member will be responsible at the time and place of service to pay any Coinsurance directly to the Dental Provider. In other instances, the Plan Member will be billed by the Dental Provider. These arrangements are between the Plan Member and the Dental Provider.

COVERAGE YEAR means when services are covered under this Plan. This means that benefit maximums, Deductibles and Coinsurance limits start and stop during this time. This Dental Plan's Coverage Year is January 1 through December 31.

COVERED EXPENSES are charges for services that are covered under the Plan. Some charges, although eligible, may be subject to Deductible and Coinsurance provisions where applicable and, therefore, are the Plan Member's responsibility to pay. Charges for non-covered expenses are also the Plan Member's responsibility.

COVERED SERVICE means Dental Services described in the Schedule of Coverage section for which Dental Plan benefits will be provided, unless limited or excluded in the Exclusions section of this Dental Plan. A Covered Service is incurred on the date the Dental Service is received.

DEDUCTIBLE means the amount of Covered Expenses payable by the Plan Member each Calendar Year before benefits are paid by the Plan.

DENTAL PROVIDER means professional Dental Providers providing dental services to Plan Members. Each Dental Provider must be licensed, registered or certified by the appropriate state agency where the dental services are performed. Where there is no appropriate state agency, the Dental Provider must be registered or certified by the appropriate professional body. Dental Provider Includes those listed below:

1. **DENTIST** - a Doctor of Dental Surgery (D.D.S.), Oral Pathologist, Oral Surgeon or Doctor of Dental Medicine (D.M.D.).
2. **ORTHODONTIST** – a Dentist who has been specially trained to do orthodontics.
3. **DENTAL HYGIENIST** - a duly licensed Dental Hygienist who works under the supervision of a Dentist.

DENTAL SERVICES means the provision of all dental treatment as defined in the Dental Plan.

DENTALLY NECESSARY means dental care services, supplies or treatment, which are required to treat the Plan Member's condition or Injury. The Plan will determine whether a service or supply is Dentally Necessary based on the review process and generally accepted dental practice. The service or supply must be:

1. Consistent with and appropriate for the treatment or diagnosis of the Plan Member's symptoms, disease, defect or Injury.
2. Of proven value or usefulness, likely to yield additional information, and not redundant when performed with other procedures.
3. The most appropriate and cost-effective level of service or supply which can safely be provided to the Plan Member.

4. Not primarily for the convenience of the Plan Member's family or the Dentist.
5. Appropriate with regard to standards of generally accepted dental practice.

The fact that a Dentist has prescribed, ordered, recommended or approved a treatment, service, or supply does **NOT** in itself make it eligible for payment.

DEPENDENT includes only an Employee's:

1. Spouse (Spouse means an individual as recognized as a spouse for purposes of federal tax laws, including the Code. A Spouse who is legally separated or divorced from the Employee is specifically excluded from the definition of Spouse.); and
2. Unmarried or married children who are less than 26 years of age;
3. Unmarried children age 26 or older who are incapable of self-sustaining employment because of a developmental disability or physical disability and are chiefly dependent upon the Employee for support and maintenance. Proof of such incapacity must be furnished within 31 days of the children reaching the limiting age and annually thereafter.

"Developmental disability" means substantial handicap which results from mental retardation, cerebral palsy, or other neurological disorder.

"Physical disability" means a physical impairment that substantially limits one or more major life activities such as hearing; breathing; mobility (ability to move); learning; or receptive (understanding) and expressive language. Physical disabilities include but are not limited to: blindness/visual impairment; cancer; diabetes; head injury; heart disease; and mobility impairments. An individual with a minor, non-chronic condition of short duration, such as a sprain, broken limb, or the flu, is not considered disabled.

4. Child for whom coverage is required by a Qualified Medical Child Support Order or by an administrative process established under state law.

The term children includes the following:

1. A biological child;
2. An adopted child, including a child placed for adoption. Placement for adoption occurs when an Employee, in anticipation of adopting a child,

assumes and retains legal obligation for the total or partial support of that child. Adoptive placement ceases when or if legal obligation ceases;

3. A stepchild;
4. a child for whom the Employee and/or the Employee's Spouse has been named legal guardian, or
5. A child for whom the Employee is legally financially responsible.
6. A foster child.

At any time, the Plan may require proof that a spouse or child qualifies or continues to qualify as a Dependent as defined by the Plan.

Individuals specifically excluded from the definition of a Dependent are:

1. any person on active military duty;
2. the grandchild of an Employee and/ or the Employee's Spouse;
3. any person covered under this Plan as an Employee; and
4. any person covered as a Dependent by another Employee.

EBSO means EBSO, Inc.

EFFECTIVE DATE means the date on which a person's coverage under this Plan begins.

EMPLOYEE means an Employee of the Employer who is regularly scheduled to actively perform the principle duties of his/her occupation a minimum of 30 hours per week, and who is enrolled and eligible for coverage under the Plan.

Part-time, seasonal, temporary and retired employees are not eligible for coverage under the Plan. Employee does not include the following:

1. a self-employed individual as described in Section 401 (c) of the Code, including, but not limited to, a sole proprietor if the Employer is a sole proprietorship, a person owning more than 2% of the Employer if it is a Subchapter S corporation, a partner of the Employer if it is a partnership, and a member of the Employer if it is a limited liability company and the members are treated as partners for income tax purposes;
2. an employee who is a spouse, child, grandchild, or parent of a person owning more than 2% of the Employer if it is a Subchapter S corporation;

3. any individual included within a unit of employees covered by a collective bargaining unit unless such agreement expressly provides for coverage of the Employee under the Plan;
4. any individual who is a nonresident alien and receives no earned income from the Employer from sources within the United States;
5. any individual who is a leased employee as defined in Section 414(n)(2) of the Code;
6. any individual who performs services for the Employer through, and is paid by, a third-party (including but not limited to an employee leasing or staffing agency) even if such individual is subsequently determined to be a common law employee of the Employer; or
7. any individual who performs services for the Employer pursuant to a contract or agreement (whether verbal or written) which provides that such individual is an independent contractor or consultant, even if such individual is subsequently determined to be a common law employee of the Employer.

EMPLOYER means City of San Luis.

EXPERIMENTAL/INVESTIGATIONAL/INVESTIGATIVE means a drug, device, medical treatment or procedure that meets any of the following:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. The drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or
3. Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

For purposes of this definition, Reliable Evidence means published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

IMMEDIATE FAMILY means the Plan Member's spouse, parent, child, stepchild, foster child, legally adopted child, grandchild, sister, brother, grandparent, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law or son-in-law.

INJURY means a condition caused by accidental means which results in damage to the Plan Member's body from an external force and independently of all other causes and which is **NOT** related to occupation or employment. Chewing accidents are **NOT** considered Injuries.

LIFETIME wherever used in the Plan in reference to benefit maximums and limitations, means while covered under the Plan. Under no circumstances does "**Lifetime**" mean during the lifetime of the Plan Member.

MASTER PLAN DOCUMENT means the Plan Document detailing the provisions of the Plan.

MEDICAID means the medical benefits provided by Title XIX of the Social Security Act, as amended.

MEDICARE means the medical benefits provided by Title XVIII of the Social Security Act, as amended.

PAYMENT PERCENTAGE means the amount payable by the Plan for Covered Expenses after satisfaction of the Deductible amount, if applicable. The Payment Percentage is shown in the Schedule of Coverage.

PHYSICIAN means a legally licensed doctor of medicine and Surgery, doctor of dental medicine or doctor of dental Surgery. A Physician shall not include the Plan Member or any member of his/her Immediate Family.

PLAN means the Plan of benefits offered by the Employer according to the provisions of the Master Plan Document.

PLAN MEMBER means an Employee or Dependent, as defined in the Master Plan Document, who is covered by the Plan.

PLAN YEAR means the twelve month period beginning from the effective date of this Plan. This Plan's Plan Year is July 1st through June 30th. The Plan Year may not be the same as the Coverage Year.

PROTECTED HEALTH INFORMATION (PHI) means health information that is created or received by a Covered Entity, or Employer, and relates to:

1. A person's past, present or future physical or mental health;
2. Provision of health care to that person; or
3. Past, present or future payment for that person's health care.

To be considered Protected Health Information the information must be "individually identifiable health information" which means that in addition to the above requirements, the health information must identify the individual or a reasonable basis must exist to believe that an individual can be identified using the information. Protected Health Information covers information in any form (electronic, oral or written).

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) means a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Plan Member or eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address of the Plan Member and the name and mailing address of each such Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and

4. The name of this Plan.

In addition, a National Medical Support Notice (NMSN) shall be deemed a QMCSO if it:

1. Contains the information set forth below;
 - a. Name of an issuing state agency;
 - b. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Plan Member) or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate recipient(s);
 - c. Identity of an underlying child support order;
2. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated;
3. Informs the Plan Administrator that, if a group health plan has multiple options and the Plan Member is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and
4. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated Dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to Plan Members, except to the extent necessary to meet the requirements of a state law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

SCHEDULE OF COVERAGE means the Schedule at the beginning of the Master Plan Document, or as later amended, which specifies the level of benefits provided by the Plan.

SICKNESS means a disorder of the body, disease, or condition.

SUMMARY HEALTH INFORMATION may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

USUAL, CUSTOMARY AND REASONABLE FEE means a charge for a given service by a provider to the majority of his clients, but such charge must be one which is within the range of fees charged by the majority of providers of similar training and experience, for that service within a specific, limited geographic or socioeconomic area as determined by the Plan. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill or expertise.

The term "area" as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross-section of a level of expenses.

SECTION D

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

EMPLOYEE ELIGIBILITY DATE

For new Employees, coverage becomes available on the first of the month following the date of hire.

Employee absences due to health related factors will be credited toward the eligibility waiting periods. **NOTE:** The Plan will give credit for any waiting periods satisfied in whole or in part under the Employers' previous plan of benefits.

The above requirement regarding length of employment shall be waived in any instance where a Plan Member is merely changing from Dependent status to Employee status, or vice versa. In these instances, coverage shall continue without interruption.

If an Employee loses coverage in this Plan due to Injury, Sickness, layoff, or Employer approved leave of absence and returns to work for the Employer within 3 months of the loss of coverage, he/she will be eligible for coverage on the date of return to work and will **NOT** have to satisfy a new waiting period.

NOTE: If an Employee does not enroll for coverage under this Plan when he/she is initially eligible to enroll for coverage, he/she may enroll for coverage under this Plan at a later date subject to the Special Enrollment Period or the Open Enrollment Period, as explained elsewhere in the Plan Document.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

Coverage becomes effective on the date the eligibility requirement is satisfied, provided the Employee has enrolled for coverage within 30 days from the date he/she first satisfied the eligibility requirements.

DEPENDENT ELIGIBILITY DATE

An Employee becomes eligible for Dependent coverage on the later of:

1. The date the Employee becomes covered;
2. The date the Employee acquires an eligible Dependent; or

3. The date the Employee is required, by a Qualified Medical Child Support Order or by an administrative process established under state law, to provide Dependent coverage.

DEPENDENT EFFECTIVE DATE OF COVERAGE

A Dependent whose coverage is required under a medical support order will be eligible to participate in the Plan as of the date specified in the order, provided the medical support order satisfies the requirements of Arizona law. The Employer will review a medical support order and determine whether it is qualified under Arizona law. Upon request to the Employer, Members may obtain a copy of the procedures governing medical support order determinations, which is available at no charge.

All other Dependent coverage will become effective on the first of the month following one month from the Employee's date of hire. If Dependent status is acquired after the Employee's initial eligibility, the effective date of coverage shall be one month following the month in which the new Dependent becomes eligible for coverage under the Plan, provided the Employee completes a change form and submits it to the Employer within thirty (30) days after the attainment of Dependent status.

Individuals who become an eligible Dependent of an Employee after the Employee's Effective Date of coverage will be eligible for coverage as explained under the CHANGE IN STATUS provision.

NOTE: If an Employee does not enroll his/her eligible Dependents for coverage under this Plan when they are initially eligible to be enrolled for coverage, the Employee may enroll his/her eligible Dependents for coverage under this Plan at a later date subject to the Special Enrollment Period or the Open Enrollment Period, as explained elsewhere in the Plan Document.

CHANGE IN STATUS

If an Employee is covered for single coverage and wants to change to family coverage because of a change in marital status, he/she must request family coverage within 31 days of the date of marriage, in order for coverage to become effective on the date of the marriage.

Should an Employee's marital status change due to divorce or legal separation, notification of that change must be given to the Employer within 60 days of the date of that change.

Employees who have single coverage may request a change to family coverage to add an eligible Dependent child, by submitting a new enrollment form within 31 days of acquiring the child as an eligible Dependent, in which case the child's coverage would become effective on the date he/she became an eligible Dependent of the Employee.

Notwithstanding the foregoing, with respect to an Employee who acquires a new Dependent via birth, adoption, or placement for adoption, coverage for the new Dependent shall begin immediately upon birth, adoption, or placement for adoption and shall not be conditioned upon the enrollment of the new Dependent. However, if an additional premium is charged for the new Dependent and if the new Dependent fails to enroll within the thirty-one (31) day time period referenced above, the coverage shall cease upon expiration of such time period. Even if no additional premium is charged, the Employee should notify the Employer of the birth, adoption, or placement for adoption.

Any request for coverage after the 31 days will be subject to the Special Enrollment Period provision or the Open Enrollment Period.

SPECIAL ENROLLMENT PERIOD

If an Employee declines coverage for himself/herself or for his/her Dependents (including the Employee's spouse) because of other health coverage, the Employee will be able to enroll himself/herself and/or his/her Dependents in this Plan at a future date, provided that the Employee requests coverage within 31 days after other coverage ends. Coverage becomes effective on the first of the month following the date on which the request for enrollment was received by the Employer.

This special enrollment period **ONLY** applies to individuals whose prior Creditable Coverage:

1. Was under COBRA and they exhausted that COBRA coverage; or
2. Was not under COBRA and they lost that prior Creditable Coverage due to:
 - a. events that are similar to COBRA qualifying events (including, but not limited to loss of eligibility as a result of legal separation, divorce, death, termination or reduction in hours of employment or a child aging out under other parent's coverage);
 - b. the plan no longer offering any benefits to a class of similarly situated individuals (e.g. part-time employees);
 - c. the cessation of the employer contributions for that prior Creditable Coverage (actual termination of other coverage is not required);
 - d. moving out of an HMO's service area; or
 - e. reaching a lifetime limit for all benefits.

However, loss of eligibility does **NOT** include a loss due to failure of the individual to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

An Employee must make a request for Special Enrollment within 31 days of the loss of the previous Creditable Coverage and must supply the Plan with proof of loss of coverage under the other group health plan.

Additional Special Enrollment rights exist for Employees and their Dependents (who are eligible but not enrolled for coverage) upon either (1) termination of Medicaid or the State Children's Health Insurance Program (SCHIP) coverage resulting from loss of eligibility; or (2) becoming eligible for premium assistance in this Plan under a Medicaid or SCHIP program. In order to be entitled to this Special Enrollment right, the Employee must request coverage within 60 days of termination or the date the parent or child is determined to be eligible for assistance.

In addition, if an Employee, who declined coverage in this Plan for himself/herself or for his/her Dependents, acquires a new Dependent as a result of marriage, birth, adoption, or placement for adoption, the Employee will be allowed to enroll for coverage for himself/herself and/or his/her spouse and/or the new child, provided that the Employee requests coverage within 31 days after the marriage, birth, adoption or placement for adoption.

EXAMPLES:

1. In the case of marriage, an Employee who had previously declined coverage could become covered, with or without his/her spouse, under the Special Enrollment Period provision. Coverage becomes effective on the date of marriage.
2. In the case of birth or adoption, an Employee and/or his/her spouse, who had previously declined coverage in this Plan could become covered under the Special Enrollment Period provision. Coverage becomes effective on the child's date of birth, adoption or placement for adoption.

NOTE: During a Special Enrollment, the Employee may add a new Dependent under the Employee's current plan option or the Employee may switch to another option, **if applicable** (e.g., an Employee who is covered under this Plan may switch to an HMO plan offered by the Employer or change from one option under this Plan to another option under this Plan).

OPEN ENROLLMENT PERIOD

If an Employee declines coverage for himself/herself or for his/her Dependents (including the Employee's spouse) at the time such individuals are eligible for coverage, the Employee will be able to enroll himself/herself and/or his/her eligible Dependents during any Open Enrollment Period. Each year, during the month of **May**, the Employer will offer an Open Enrollment Period to eligible individuals (Employees and Dependents) who are not already covered under this Plan. Any individual enrolling for coverage under this Plan during an Open Enrollment Period (other than a new Employee who has not yet satisfied his/her eligibility-waiting period) will have coverage effective on the first of July.

NOTE: An Employee's eligible Dependent(s) may **NOT** be covered under this Plan unless the Employee is also covered. (This limitation does not apply to COBRA coverage.)

CHOOSING PLAN OPTIONS

Every year, during the month of May, the Employer will offer an annual enrollment period, during which an Employee who is presently enrolled under one Plan Option may elect to become enrolled in an alternate Plan Option. The effective date of the change in Plan Option will be July 1.

Employees who are presently enrolled under one Plan Option may also elect to become enrolled in an alternate Plan Option if they experience a family status change. A family status change will occur if the Employee gains or loses an eligible Dependent due to divorce, death, loss of eligibility, birth, marriage, adoption or a child reaching the maximum age limit.

Dependents covered by that Employee must be covered under the same Plan Option.

TERMINATION OF INDIVIDUAL COVERAGE

Coverage under this Plan shall terminate at midnight on the earliest of the following:

1. The date the Plan is terminated for all Plan Members;
2. The date a required contribution, if any, is due but the Plan Member fails to make the contribution;
3. With regard to a specific benefit, on the date the benefit is terminated or deleted from the Plan;
4. The date the Plan Member requests termination of any or all coverage under the Plan, subject to IRS Cafeteria rules. The request for termination must be in writing and all forms required by the Plan Administrator must be completed;

5. For Employees: If an Employee does not work the required number of hours to be considered an eligible Employee for any reason other than those specifically listed above, (i.e.; voluntary or involuntary termination of employment; or reduction in hours), coverage will terminate at the end of the month in which the Employee ceases full-time active work;
6. For Dependents:
 - a. Coverage will terminate on the same day as coverage terminates for the Employee under whom they are covered;
 - b. Coverage will terminate at the end of the month in which the individual no longer meets the Plan's Definition of an eligible Dependent;
 - c. For Dependents whose coverage became effective upon their birth, adoption, or placement for adoption under Change in Status, coverage will terminate on the date thirty-one (31) days from the effective date of coverage if an additional premium is charged for the new Dependent and the new Dependent fails to enroll with-in thirty-one (31) days following the birth, adoption, or placement for adoption.
 - d. Coverage will terminate on the date as specified in the Qualified Medical Child Support Order or by an administrative process established under state law if eligibility for Dependent coverage is solely based on this order.

NOTE: Coverage shall be canceled automatically, without notice, if a Plan Member:

1. Attempts, through deceit, to obtain benefits that otherwise would not be provided by this Plan; or
2. Attempts to obtain benefits for someone not entitled to benefits under this Plan.

Rescission. Coverage under this Plan may be Rescinded under certain circumstances. A determination by the Plan that a Rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Plan Member whose coverage is being Rescinded will be provided a 30 day notice period as described under Health Care Reform and regulatory guidance. Such notice shall be considered an Adverse Benefit Determination. At the conclusion of the 30 day notice

period, coverage shall be terminated retroactive to the date identified in the notification. Claims incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims.

This Plan shall at all times be in compliance with the applicable state family medical leave act and/or the Family and Medical Leave Act (FMLA) of 1993, or as later amended, provided the Employer is required to comply with such acts. The FMLA will run concurrently with any extension of coverage specified above.

SECTION E

CONTINUATION OF COVERAGE UPON INDIVIDUAL TERMINATION (COBRA)

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan ("Plan") offer Employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform Plan Members and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. The following paragraphs generally explain COBRA coverage, when it may become available and what a Qualified Beneficiary needs to do to protect his or her right to receive it.

We use the pronoun "you" in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a Qualified Beneficiary.

WHAT IS COBRA CONTINUATION COVERAGE? COBRA coverage is a temporary extension of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event". Specific Qualifying Events are listed below in the section entitled "What is a Qualifying Event".

The Plan has the following components, Dental, and you may be enrolled in one or more of these components. COBRA (and the description of COBRA coverage contained in the plan document and summary plan description "SPD") applies only to the group health plan benefits offered under the Plan (the Dental) and not to any other benefits offered by the Employer (such as life insurance, disability income, or accidental death or dismemberment benefits).

COBRA coverage is the same coverage that the Plan gives to other Plan Members under the Plan who are not receiving COBRA coverage. Each Qualified Beneficiary who elects COBRA will have the same rights under the Plan as other Plan Members covered under the component or components of the Plan elected by the Qualified Beneficiary, including Open Enrollment and Special Enrollment rights.

If an Employer offers more than one level of benefits and also offers an Open Enrollment Period (during which time, Plan Members are allowed to change to a different level of benefits or to add additional coverage, such as dental or vision), Qualified Beneficiaries must also be allowed to make these selections during an Open Enrollment Period.

In considering whether or not to take COBRA, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. You will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not obtain continuation coverage for the maximum time available to you. You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the Qualifying Event. You will also have the same special enrollment right at the end of continuation coverage if you obtained continuation coverage for the maximum time available to you.

WHO IS A QUALIFIED BENEFICIARY? In general, a Qualified Beneficiary is:

1. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the spouse of a covered Employee, or a Dependent child of a covered Employee.
2. A child born to, adopted by, or placed for adoption with a covered Employee during a period of COBRA coverage is considered to be a Qualified Beneficiary provided that, if the covered Employee is a Qualified Beneficiary, the covered Employee has elected COBRA coverage for himself/herself. The child's COBRA coverage begins when the child is enrolled in the Plan, including when enrolled through a Special Enrollment or an Open Enrollment.
3. A child who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO), received by the Employer during the covered Employee's period of employment with the Employer, is entitled to the same rights to elect COBRA as an eligible Dependent child of the covered Employee.

If however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer coverage constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes not only common-law Employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his/her performance of services for the Employer sponsoring the Plan (e.g., self-employed individuals, independent contractors, owners or corporate directors).

WHAT IS A QUALIFYING EVENT? If you are a covered **Employee** you will be entitled

to elect COBRA if you lose your group health coverage under the Plan because of either of the following Qualifying Events:

1. your hours of employment are reduced; or
2. your employment ends for any reason other than your gross misconduct.

If you are a covered **spouse** of an Employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because of any of the following Qualifying Events:

1. your spouse dies;
2. your spouse's hours of employment are reduced;
3. your spouse's employment ends for any reason other than his/her gross misconduct;
4. your spouse becomes entitled to Medicare; or
5. you become divorced or legally separated from your spouse. Also, if your spouse (the Employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event for you even though your coverage was reduced or eliminated before the divorce or legal separation.

If you are a covered **Dependent child** of an Employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because of any of the following Qualifying Events:

1. the Employee dies;
2. the Employee's hours of employment are reduced;
3. the Employee's employment ends for any reason other than his/her gross misconduct;
4. the Employee becomes entitled to Medicare;
5. the parents of the Dependent child become divorced or legally separated; or
6. you stop being eligible for coverage under the Plan as a Dependent child.

If an Employee takes FMLA leave and does not return to work at the end of the leave, the Employee (and the Employee's spouse and Dependent children, if any) will be

entitled to elect COBRA if:

1. they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and
2. they will lose Plan coverage within 18 months because of the Employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave.)

If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the Employee and Dependents will be entitled to COBRA coverage even if they failed to pay the Employee portion of the contribution for coverage under the Plan during the FMLA leave.

WHEN IS COBRA COVERAGE AVAILABLE? When the Qualifying Event is the end of employment, reduction of hours of employment, or death of the Employee, the Plan will offer COBRA coverage to Qualified Beneficiaries. You need not notify the Employer of any of these three Qualifying Events. An Election Form will automatically be provided.

For the other Qualifying Events (divorce or legal separation of the Employee and spouse, or a Dependent child losing eligibility for coverage as a Dependent child), a COBRA Election Form will be sent to you only if you notify the Employer in writing within 60 days after the date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the Qualifying Event.

WHAT IS THE ELECTION PERIOD AND HOW LONG MUST IT LAST? An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Employer's Plan. A Plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of his/her right to elect COBRA continuation coverage.

HOW MAY COBRA COVERAGE BE ELECTED? To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA election notice and submit it to the COBRA Administrator.

Mail, hand-deliver or fax the completed Election Form to:
COBRA/Eligibility Department

EBSO, Inc.
2145 Ford Parkway, Suite 200
St. Paul, Minnesota 55116-1912
(651) 695-2500 or 1-800-486-7664
Fax number (651)695-1648

The Election Form must be completed in writing and mailed, hand-delivered, or faxed to the individual at the address/fax number specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; electronic communications, including e-mail messages; and faxed communications (unless they are on a proper Election Form).

If mailed, your Election Form must be postmarked (and if hand-delivered or faxed, your Election Form must be received by the individual at the address/fax number specified above) no later than 60 days after the date of the COBRA election notice provided to you at the time of your Qualifying Event. **IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.**

Each Qualified Beneficiary (including a child who is born to, adopted by or placed for adoption with a COBRA covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage. Covered Employees and spouses (if the spouse is a Qualified Beneficiary) may elect COBRA on behalf of all of the Qualified Beneficiaries, and parents may elect COBRA on behalf of their children.

Qualified Beneficiaries may be enrolled in one or more group health components of the Plan at the time of a Qualifying Event. If a Qualified Beneficiary is entitled to a COBRA election as the result of a Qualifying Event, he/she, may elect COBRA under any or all of the group health components of the Plan under which he/she was covered on the day before the Qualifying Event.

When you complete the Election Form you must notify the Employer if any Qualified Beneficiary has become enrolled under Medicare (Part A, Part B, or both) and, if so, the date of Medicare enrollment. If you become enrolled under Medicare (or first learn that you are enrolled under Medicare) after submitting the Election Form, immediately notify the Employer of the date of your Medicare enrollment at the address specified for delivery of the Election Form.

Qualified Beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are enrolled under Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he/she becomes enrolled under Medicare benefits or becomes covered under

other group health plan coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied). See the section entitled “When may a Qualified Beneficiary’s COBRA continuation coverage be terminated?”.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the COBRA Administrator.

If you reject COBRA before the due date, you may change your mind as long as you furnish a completed Election Form before the due date.

WHAT ARE THE MAXIMUM COVERAGE PERIODS FOR COBRA CONTINUATION COVERAGE? The maximum coverage periods are based on the type of Qualifying Event and the status of the Qualified Beneficiary, as shown below:

1. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
2. In the case of a covered Employee’s enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
 - a. 36 months after the date the covered Employee becomes enrolled in the Medicare program. For example, if a covered Employee becomes enrolled under Medicare eight months before the date on which his employment terminates, COBRA coverage under the Plan for his spouse and Dependent children who lost coverage as a result of his termination can last up to 36 months after the date the Employee became enrolled under Medicare, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months). This COBRA coverage period is available only if the covered Employee becomes enrolled under Medicare within 18 months **BEFORE** the termination or reduction of hours; or
 - b. 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee’s termination of employment or reduction of hours of employment.
3. In the case of any other Qualifying Event than those described above, the

maximum coverage period ends 36 months after the Qualifying Event.

4. In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retired Employee ends on the date of the covered retired Employee's death. The maximum coverage period for a Qualified Beneficiary who is the surviving spouse or Dependent child of the covered retired Employee ends on the earlier of the date of the Qualified Beneficiary's death or the date that is 36 months after the death of the covered retired Employee.

In the case of a Qualified Beneficiary who is a child born to, adopted by or placed for adoption with a COBRA covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born, adopted or placed for adoption.

UNDER WHAT CIRCUMSTANCE CAN THE MAXIMUM COVERAGE PERIOD BE EXPANDED? If the Qualifying Event that resulted in your COBRA election was the covered Employee's termination of employment or reduction in hours, an extension of the maximum coverage period may be available if a Qualified Beneficiary is disabled or a second Qualifying Event occurs. You must notify the Employer of a disability or a second qualifying event in order to extend the period of COBRA coverage. **FAILURE TO PROVIDE NOTICE OF A DISABILITY OR SECOND QUALIFYING EVENT WILL ELIMINATE THE RIGHT TO EXTEND THE PERIOD OF COBRA COVERAGE.**

1. **Disability extension of COBRA coverage.** If a Qualified Beneficiary is determined by the Social Security Administration to be disabled and you notify the Employer in a timely fashion, all of the Qualified Beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for Qualified Beneficiaries who are receiving COBRA coverage because of a Qualifying Event that was the covered Employee's termination of employment or reduction in hours. The disability must have started at some time before the 61st day after the covered Employee's termination of employment or reduction of hours (this includes disabilities that began prior to the Employee's termination of employment or reduction of hours). The disability must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each Qualified Beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if you notify the Employer in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- a. the date of the Social Security Administration's disability

determination;

- b. the date of the covered Employee's termination of employment or reduction of hours; or
- c. the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered Employee's termination of employment or reduction of hours.

You must provide the Social Security Administration's determination notice within 18 months after the covered Employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

2. **Second Qualifying Event extension of COBRA coverage.** An extension of coverage will be available to spouses and Dependent children who are receiving COBRA coverage if a Second Qualifying Event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered Employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a Second Qualifying Event occurs is 36 months. Such Second Qualifying Events may include the death of a covered Employee, divorce or legal separation from the covered Employee, or a Dependent child's ceasing to be eligible for coverage as a Dependent under the Plan. These events can be a Second Qualifying Event only if they would have caused the Qualified Beneficiary to lose coverage under the Plan if the first Qualifying Event had not occurred. (This extension is not available under the Plan when a covered Employee becomes enrolled under Medicare.)

This extension due to a Second Qualifying Event is available only if you notify the Employer in writing of the Second Qualifying Event within 60 days after the later of:

- a. the date of the Second Qualifying Event; or
- b. the date on which the Qualified Beneficiary would lose coverage under the terms of the Plan as a result of the Second Qualifying Event (if it had occurred while the Qualified Beneficiary was still covered under the Plan).

WHAT IS THE COST OF COBRA CONTINUATION COVERAGE? The amount a Qualified Beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the group health Plan for coverage of a similarly situated Plan Member who is not receiving COBRA coverage (including both Employer and Employee contributions). The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA

premium changes.

WHAT ARE THE COBRA CONTINUATION COVERAGE PAYMENT PROCEDURES?

If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage no later than 45 days after the date of your election. (This is the date your Election Form is postmarked, if mailed, or the date your Election Form is received by the individual at the designated address/fax number, if hand-delivered or faxed.) See the section above entitled “How may COBRA coverage be elected?”

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make the first payment. (For example, your employment terminates on September 30, and you lose coverage on September 30. You elect COBRA coverage on November 15. Your initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of your COBRA election.) You are responsible for making sure that the amount of your first premium payment is correct. You may contact the Employer using the contact information provided under the section entitled “How may COBRA coverage be elected?” to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, YOU WILL LOSE ALL COBRA RIGHTS UNDER THE PLAN.

After you make your first payment for COBRA coverage you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each Qualified Beneficiary will be disclosed in the election notice provided to you at the time of your Qualifying Event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. Following your election of COBRA coverage, you will receive a packet of 12 coupons to submit with your monthly COBRA premium. Periodic notices of payments due for these coverage periods will not be sent (that is, a monthly bill will not be sent to you for your COBRA coverage – it is your responsibility to pay your COBRA premiums on time).

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that

payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, YOU WILL LOSE ALL RIGHTS TO COBRA COVERAGE UNDER THE PLAN.

All COBRA premiums must be paid by check or money order. CASH WILL NOT BE ACCEPTED.

Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to:

COBRA/Eligibility Department
EBSO, Inc.
2145 Ford Parkway, Suite 200
St. Paul, Minnesota 55116-1912
(651) 695-2500 or 1-800-486-7664
Fax number (651)695-1648

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand-delivering a check if your check is returned due to insufficient funds or otherwise.

WHEN MAY A QUALIFIED BENEFICIARY'S COBRA CONTINUATION COVERAGE BE TERMINATED? COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can terminate before the end of the maximum coverage period for several reasons, which are described below.

COBRA coverage will automatically terminate before the end of the maximum coverage period if:

1. timely payment is not made to the Plan with respect to the Qualified Beneficiary. **NOTE:** Invalid payments (i.e., checks returned due to insufficient funds) will result in retroactive termination of coverage.
2. the Employer ceases to provide any group health plan (including successor plans) to any Employee.

3. a Qualified Beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the Qualified Beneficiary have been exhausted or satisfied).
4. a Qualified Beneficiary first becomes enrolled under Medicare benefits (Part A, Part B, or both) after electing COBRA.
5. during a disability extension period, the disabled Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled.

You must notify the Employer in writing within 30 days if, after electing COBRA, a Qualified Beneficiary becomes enrolled under Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the Qualified Beneficiary have been exhausted or satisfied). COBRA coverage will terminate (retroactively, if applicable) as of the date of Medicare enrollment or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any pre-existing condition exclusions for a pre-existing condition of the Qualified Beneficiary). The Employer will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare enrollment or other group health plan coverage.

If a disabled Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Employer of that fact within 30 days after the Social Security Administration's determination. If the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all Qualified Beneficiaries will terminate (retroactively, if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled. The Employer will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice that the disabled Qualified Beneficiary is no longer disabled. (For more information about the disability extension period, see the section above entitled "Under what circumstances can the maximum coverage period be expanded?")

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a Plan Member not receiving COBRA coverage (such as fraud).

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

DOES A QUALIFIED BENEFICIARY HAVE A DUTY TO KEEP THE PLAN INFORMED OF ADDRESS CHANGES?

In order to protect your family's rights, you must keep the Employer and the Plan's Claims Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Employer and the Plan's Claims Administrator.

QUESTIONS? If you have questions about your COBRA continuation coverage, you should contact the Employer or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

CONTACTS: You may obtain information about COBRA coverage on request from:

1. The Employer (Plan Administrator):

City of San Luis
1090 E. Union Street
San Luis, AZ 85349
928-341-8547

2. COBRA Administrator:

COBRA/Eligibility Department
EBSO, Inc.
2145 Ford Parkway, Suite 200
St. Paul, Minnesota 55116-1912
(651) 695-2500 or 1-800-486-7664
Fax number (651)695-1648

The contact information for the Plan may change from time to time. The information will be included in the Plan's most recent SPD (if you are not sure whether this is the Plan's most recent SPD, you may request the most recent one from the Employer).

YOU MUST GIVE NOTICE OF CERTAIN QUALIFYING EVENTS

If you or your Dependent(s) experience any of the following qualifying events, you or your Dependent(s) must notify the Plan Administrator/COBRA Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would end as a result of the qualifying event:

- your divorce or legal separation.
- your child no longer qualifies as a Dependent under the Plan.
- the occurrence of a secondary qualifying event as described in "Second Qualifying Event extension of COBRA coverage" (this notice must be received prior to the end of the initial 18-month or 29-month COBRA period). See "Disability extension of COBRA coverage" for additional notice requirements.

Notice must be made in writing and must include: the name of the Plan; name and address of the Employee covered under the Plan; name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g. divorce decree, birth certificate, disability determination, etc.).

SECTION F

UNIFORMED SERVICES CONTINUATION AND REINSTATEMENT PROVISION

Continuation

A Plan Member who:

1. Is employed by the Employer;
2. Is determined by the Employer to be eligible for benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA);
3. Is absent from his/her position of employment with the Employer by reason of service in the uniformed services; and

4. Would otherwise have his/her coverage under the Plan terminated,

may elect to continue the coverage under the Plan that the Plan Member and his/her eligible covered Dependents had prior to such absence for a period not to exceed the lesser of:

1. The twenty four month period beginning on the date on which the Plan Member's absence begins; or
2. The day after the date on which the Plan Member fails to apply for or return to a position of employment as specified by the Employer.

Reinstatement

Upon re-employment, coverage under the Plan will be reinstated for a person who was absent from his/her position of employment with the Employer by reason of service in the uniformed services, as well as for his/her eligible Dependents who were covered Plan Members under the Plan at the time the absence began provided that:

1. The person was a covered Plan Member under the Plan until the time his/her absence from employment with the Employer commenced by reason of service in the uniformed services;
2. The person makes application for re-employment within the time limit specified by the Employer; and

3. At the time the person makes application for re-employment, he/she is entitled to benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

In such instances, an exclusion of the Plan, Pre-existing Condition Limitation, or waiting period will not be applied, if that exclusion of the Plan, Pre-existing Condition Limitation, or waiting period would not have been applied had coverage not been terminated as a result of service in the uniformed services. This also applies to any eligible Dependent of the covered person who becomes covered by the Plan as a result of such reinstatement of coverage.

An exclusion or waiting period may be imposed for any Injury or Sickness determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of service in the uniformed services.

SECTION G

GENERAL LIMITATIONS AND EXCLUSIONS

Notwithstanding any provision in the Plan to the contrary, the Plan will not provide benefits for the following services, dental procedures or supplies, regardless of Dental Necessity or recommendation by a Dental Provider. The Plan Member is responsible for 100% of the expenses associated with the listed exclusions. These expenses are not Covered Services and, therefore, will not count toward the Annual Out-of-Pocket Maximum.

1. Charges for any device ordered while the Plan Member was covered under this Dental Plan and not delivered or installed within thirty (30) days after termination of coverage.
2. Replacement of duplicate, lost missing or stolen appliances or prosthetic devices.
3. Charges for all services, supplies and treatment related to dental implants.
4. Any procedure not listed as a Covered Service.
5. Any procedure that began before the date the Plan Member's dental coverage started to include a service which is:
 - a. An appliance, or modification of an appliance, for which an impression was made before such person became covered under the Dental Plan;
 - b. A crown, bridge or gold restoration, for which a tooth was prepared before such person became covered under the Dental Plan;
 - c. Root canal therapy, for which the pulp chamber was opened before such person became covered under the Dental Plan.

X-rays and prophylaxis shall not be deemed to start a dental procedure.

6. Services, supplies or treatment that is cosmetic in nature, including charges for personalization or characterization of dentures. Veneers or porcelains posterior to the second bicuspid are considered optional, and as such, are not Covered Services.
7. Surgical services with respect to congenital or developmental malformations. These conditions include: cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis, and anodontia.

8. Appliances, restoration or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting or replacing tooth structure lost as a result of abrasion or attrition, except as provided under Orthodontic Services.
9. Charges for services, supplies or treatment for which benefits are payable under any employer sponsored group medical or dental plan.
10. A service not furnished by a Dentist, except;
 - a. That performed by a licensed dental hygienist under a Dentist's supervision;
 - b. X-rays ordered by a Dentist; and
 - c. Denturist.
11. Charges for over-dentures, including related root canal therapy and supportive restorations.
12. Replacement of a prosthetic which in the Dentist's opinion can be repaired or does not need replacement.
13. Fixed prosthetics and/or partials for Plan Members through the age of fifteen. An allowance will be made for a temporary acrylic partial.
14. A posterior fixed prosthetic appliance when done in connection with a removable appliance in the same arch.
15. Charges in excess of the least costly plan of treatment when there is more than one accepted method of treatment for a dental condition.
16. Charges resulting from changing from one Dentist to another while receiving treatment, or from receiving care from more than one Dentist for one dental procedure, to the extent the total charges billed exceed the amount that would have been billed if one Dentist had performed all the required Dental Services.
17. Porcelain, gold, porcelain veneer, acrylic veneer, and precious metal crowns over primary teeth for Plan Members through the age of fifteen (15). An allowance will be made for an acrylic crown.
18. Charges for precision attachments, semi-precision attachments, instruction in dental plaque control, dental hygienics, or nutritional counseling.
19. Charges for services or supplies related to diagnosis of, or treatment of temporomandibular joint syndrome, by whatever name called.

20. Expenses for completion of claim forms or for preparation of medical reports; for missed appointments or for telephone consultations.
21. Charges Incurred for treatment of an Injury or Sickness sustained while the Plan Member is participating in an illegal occupation; commission of, or an attempt to commit, a felony; or voluntary participation in a riot, insurrection or civil disobedience.
22. Charges in excess of any maximum benefit stated in the Plan.
23. For expenses made which are in excess of the Usual, Customary and Reasonable Fee.
24. Expenses Incurred by a Plan Member that may be covered or reimbursed by any public program, or by any national, state, provincial, county, or local government or any other political subdivision, instrumentality or agency thereof, except Medicare and Medicaid.
25. Services furnished to the Plan Member in any veteran's Hospital, military Hospital, institution or facility operated by the United States Government, by any state government, by any agency or instrumentality of such government, or any foreign government agency, for which the Plan Member has no legal obligation to pay for services rendered or expenses Incurred, except for care or service furnished by a tax supported state Hospital for treatment of Mental/Nervous Disorders.
26. Services performed by a person who is a member of the Plan Member's Immediate Family or who resides in the Plan Member's home.
27. Expenses for which the Plan Member has no legal obligation to pay or for an expense which would not have been made if the person did not have coverage under this Plan.
28. Charges for taxes or surcharges, other than those which a medical facility is legally required to make.

SECTION H

DENTAL BENEFITS

Covered Dental Expenses

The Plan will pay benefits for Covered Expenses Incurred by a Plan Member for dental services, only when performed by a Dentist or a Dental Hygienist, or other dental provider working under the direction and supervision of the Dentist. The payment is subject to the General Limitations and Exclusions and all other provisions of the Plan. The Payment Percentages and maximums are shown in the Schedule of Coverage.

Class I Services –Preventive and Diagnostic Services

1. Teeth cleaning
2. Exams
3. Dental x-rays
4. Fluoride treatments
5. Sealants

Class II Services – Basic Services

1. Fillings (amalgam and anterior, posterior composite (white) fillings)
2. Simple extractions
3. Non-surgical periodontics
4. Endodontics (root canal therapy)

Class III Services – Major Dental Repair Services

1. Restorative crowns
2. Restorative onlays
3. Bridges
4. Dentures
5. Partial dentures

Class IV Services – Orthodontic Services.

NOTE: Dependent children must be covered under the Dental Plan for twelve (12) consecutive months before orthodontia benefits are available.

1. Active appliances. Allowance includes diagnostic services, the treatment plan, the fitting, making and placing of the active appliance, and all related office visits including post-treatment stabilization.

2. Surgical reposition of the jaw, facial bones and/or teeth to correct malocclusion and x-rays.
3. Any other Class I, II or III services that are performed in connection with orthodontic treatment shall be payable under their appropriate payment percentage and not included under the orthodontic limitations and/or payment percentages.

SECTION I

CARE PROVIDED BY THE UNITED STATES GOVERNMENT

The Plan will reimburse for care rendered by the Veterans Administration for non-service connected disabilities, on the same basis as these services are otherwise covered by the Plan.

The Plan will reimburse for care rendered by the United States to military retirees and dependents who are covered by this Plan on an inpatient basis through a facility of the uniformed services, on the same basis as these services are otherwise covered under the Plan.

COORDINATION OF BENEFITS

The Plan contains a non-profit provision coordinating it with other Plans under which an individual is covered so that total benefits available will not exceed 100% of the Allowable Expense for the services. When this Plan pays second, it will pay, with respect to each claim submitted for payment, 100% of Allowable Expenses less whatever payments were actually made by the Plan (or Plans) that paid first. In addition, when this Plan pays second, it will never pay more in benefits than it would have paid during the Plan Year for each claim as it is submitted had it been the Plan that paid first.

An "Allowable Expense" means any health care service or expense, including coinsurance, copays or copayment and without reduction for any deductible, that is covered in full or in part by any of the Plan covering the person. Allowable Expenses do not include expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under this Plan.

"Claim Determination Period" means the time during any one benefit year when a person is covered and incurs charges for services or supplies covered under this Plan and one other plan.

As each claim is submitted, each plan determines its liability and pays or provides benefits based upon Allowable Expenses incurred during the Claim Determination Period. However, that determination is subject to adjustment as later Allowable Expenses are incurred during the same Claim Determination Period.

"Plan" means any plan providing health benefits or health services including but not limited to:

1. Group, blanket or franchise insurance coverage;
2. Group practices and other group pre-payment coverage;
3. Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans; and
4. Any coverage under governmental programs, such as Medicare, Tricare/CHAMPUS, and any coverage required or provided by any statute, such as no-fault auto insurance.

"Plan" shall not include:

1. School accident type coverage;
2. Hospital indemnity coverage; or
3. Individual insurance coverage.

EFFECT ON BENEFITS

Plans determine the sequence in which they pay benefits, or which plan pays first, by applying uniform order of benefit determination rules in a specific sequence. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC). Any Plan that does not use these same rules always pays its benefit first.

When two Plans cover the same person, the following order of benefit determination rules establish which Plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until the order of benefits is established. The rules are as follows:

Rule 1: Non-Dependent/Dependent

- A. The Plan that covers a person as an employee, retiree, member or subscriber (that is, other than as a dependent) pays first; and the Plan that covers the same person as a dependent pays second;
- B. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is:

1. secondary to the Plan covering the person as a dependent; and
2. primary to the Plan covering the person as other than a dependent (that is, the Plan covering the person as a retired employee);

then the order of benefits is reversed, so that the Plan covering the person as a dependent pays first; and the Plan covering the person other than as a dependent (that is, as a retired employee) pays second.

Rule 2: Dependent Child Covered Under More Than One Plan.

- A. The Plan that covers the parent whose birthday falls earlier in the calendar year pays first; and the Plan that covers the parent whose birthday falls later in the calendar year pays second, if:
 1. the parents are married or living together;
 2. the parents are not separated (whether or not they ever have been married); or
 3. a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.
- B. If both parents have the same birthday, the Plan that has covered one of the parents for a longer period of time pays first; and the Plan that covered the other parent for the shorter period of time pays second.
- C. The word “birthday” refers only to the month and day in a calendar year, not the year in which the person was born.
- D. If the specific terms of a court decree state that one parent is responsible for the child’s health care expenses or health care coverage, and the Plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child’s health care services or expenses, but that parent’s spouse does, the Plan of the spouse of the parent with financial responsibility pays first. This rule applies to plan years commencing after the Plan is given notice of the court decree.
- E. If the parents are divorced, separated or not living together (whether or not they have ever been married), and there is no court decree allocating responsibility for the child’s health care services or expenses, the order of benefit determination among the Plans of the parents and their spouses (if any) is:
 1. The Plan of the custodial parent pays first;

2. The Plan of the spouse of the custodial parent pays second; and
3. The Plan of the non-custodial parents pays third; and
4. The Plan of the spouse of the non-custodial parent pays last.

If the dependent child is covered under a Plan of an individual other than the parents, the order of benefits is determined as if those individuals were the parents of the child. The custody rule is applicable to anyone who has legal custody of the dependent child.

Rule 3: Active/Laid-off or Retired Employee

- A. The Plan that covers a person as an active employee, that is, an employee who is neither laid-off or retired, is primary. The Plan covering that same person as a retired or laid-off employee is secondary. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee.
- B. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- C. This rule does not apply if Rule #1 described above can be used to determine the order of benefits

This rule is applicable only in the rare situations when the same individual is covered under two plans, one as an active employee and the other as a retired or laid-off employee. This rule does not apply to an individual covered under his or her own Plan as either an active, retired, or laid-off employee and also as a dependent under another Plan. In those situations, Rule #1 should be applied.

Rule 4: Continuation Coverage

- A. If a person whose coverage is provided under a right of continuation under federal or state law (e.g. COBRA) is also covered under another Plan, the Plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the Plan providing continuation coverage to that same person pays second.
- B. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

This rule is applicable only to the rare situations when an individual is covered under both COBRA and non-COBRA plans as other than a dependent, or as a dependent of an

individual who is covered under both plans as a non-dependent. In the majority of continuation coverage situations, two employee spouses are involved (one on COBRA and one on the basis as active employment). In this scenario, Rule #1 is applicable.

Rule 5: Longer/Shorter Length of Coverage

If none of the four previous rules determines the order of benefits, the Plan that covered the person for the longer period of time pays first; and the Plan that covered the person for the shorter period of time pays second.

Rule 6: None of the Above Rules Apply

If the preceding rules do not apply, the allowable expenses shall be shared equally between the Plans.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any other plan, the plan may without the consent of or notice to any persons release to, or obtain from, any insurance company or other organization or person any information with respect to any person which it deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan information as may be necessary to implement this provision.

FACILITY OF PAYMENT

Whenever payments which should have been made under the Plan in accordance with this provision have been made under any other plan, the Plan shall have the right, exercisable alone and at its sole discretion, to pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision and amounts so paid shall be deemed to be benefits paid under this Plan and to the extent of such payments for covered services, the Plan shall be fully discharged from liability.

SECTION J

MEDICARE SELECTION PROVISION

If the Employer has **less** than 20 Employees in the current Calendar Year, Medicare coverage is primary (and this Plan will be secondary) for active Employees age 65 or older and their Dependents 65 or older. This Plan will reduce payment by the amount paid or payable by Medicare.

If the Employer had 20 or **more** Employees in the current or preceding Calendar Year, Federal law requires that Medicare coverage be secondary to this Plan. The Plan Member has the option of rejecting this Plan thereby retaining Medicare as his/her primary coverage. If the Plan Member chooses Medicare as primary, the Employer cannot provide any supplemental coverage. If the Plan Member rejects coverage under this Plan that choice must be made in writing to the Employer.

Federal law also mandates which plan is primary in the case of certain persons who are totally disabled or have end stage renal disease.

NOTE: This Plan will determine the primary and secondary payment of claims based on the current rules and regulations set forth by Medicare.

SECTION K

GENERAL PROVISIONS

The Plan and The Master Plan Document

The Plan Sponsor has filed the Master Plan Document in the office of the Human Resource Department, which can be inspected at any time during normal working hours by any Plan Member.

The Plan is a legal entity. Legal notices may be filed with, and legal process served upon, the Plan Administrator.

Plan Administrator

The Plan Administrator as used herein shall be the person or firm responsible for the day to day functions and management of the Plan. The Plan Administrator is the Employer.

The construction and interpretation of the Plan are vested with the Plan Administrator, in its absolute discretion, including, without limitation, the determination of benefits, eligibility and interpretation of Plan provisions. The Plan Administrator will endeavor to act, whether by general rules or by particular decisions, so as to treat all persons in similar circumstances without discrimination. All such decisions, determinations and interpretations shall be final, conclusive and binding upon all parties having an interest in the Plan.

Named Fiduciary

The Named Fiduciary is the Plan Administrator and has the authority to control and manage the operation and administration of the program. A participant under the Plan will not receive Plan benefits unless the Plan Administrator determines that the participant is entitled to such benefits.

Claims Administrator

The Claims Administrator will provide technical services in connection with operation of the coverage and performing other functions.

The Plan Is Not A Contract

The Plan shall not be deemed to constitute a contract between the Employer and any Employee or be a consideration for, or an inducement or condition of, the employment of an Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provision of any collective bargaining agreements which may be made by the Employer with the bargaining representative of any Employees.

Exchange Of Information

The Plan will promptly provide to appropriate Federal, state and local law enforcement authorities and to other appropriate health plans:

1. Information indicating a potential violation of civil, criminal, or administrative laws relating to fraud and abuse with respect to health plans.
2. Information requested by Federal, state, or local law enforcement agencies which the agency states is relevant to an investigation, audit, evaluation, or inspection under the Federal Fraud and Abuse Control Program.
3. Information which would assist in the identification of potential violations or assist in the identification of areas requiring investigation, audit, evaluation, or inspection. Such information may include:
 - a. Surveys; Quality assurance reviews;
 - b. Provider and patient profiles;
 - c. Utilization review, and
 - d. Other similar analyses.

Alternative Treatment

The Plan Administrator has the right to approve coverage for treatment, procedures or facilities that are not normally covered under the Plan, if the Plan Administrator feels that this alternative treatment, procedure or facility offers a cost-effective method of treating the Plan Member's condition. Such approval in no way obligates the Plan Administrator to approve such coverage in the future, nor does it obligate the Plan

Administrator to approve of Alternative Treatment for any other Plan Member. Each case will be decided on its own merits.

Free Choice of Physician

Each Plan Member has a free choice of any Physician/**Dentist** or surgeon, and the Physician/**Dentist**-patient relationship shall be maintained. The Plan Member, together with his Physician/**Dentist**, is ultimately responsible for determining the appropriate course of **dental** treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

The PPO providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any PPO provider.

Qualified Medical Child Support Orders (QMCSO)

The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a “Qualified Medical Child Support Order” (“QMCSO”) if such an individual is not already covered by the Plan as an eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

“Alternate Recipient” shall mean any child of a Plan Member who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Plan Member’s eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Plan Member.

Upon receiving a Medical Child Support Order (Order), the Plan Administrator shall, as soon as administratively possible:

1. Notify the Plan Member and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan’s procedures for determining whether the Order qualifies as a QMCSO; and
2. Make an administrative determination if the Order is a QMCSO and notify the Plan Member and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice (Notice), the Plan Administrator shall:

1. Notify the state agency issuing the Notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
 - a. Whether the child is covered under the Plan; and
 - b. Either the Effective Date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator shall:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and
2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

A Plan Member may request at any time a copy of QMCSO procedures from the Plan without charge.

Other Service Plan Contracts

If any Plan Member is covered under more than one Plan, the coverage that would be provided under this Plan in the absence of this provision shall be reduced to the extent necessary so that the sum of such reduced coverage, together with the benefits, if any, that are paid or payable under such other Plan contract for health service shall not exceed the total charges for the health service.

Worker's Compensation Notice

The Plan is not in lieu of, is not in any way subject to, and does not affect any requirement for coverage by worker's compensation insurance.

Erroneous Payment Refund Provision

Covered Expenses are occasionally paid erroneously by the Plan (i.e., paid more than once; incorrectly paid under the Plan's terms, conditions, limitations or exclusions; or conditionally paid pending further review). An Employee, Dependent, or health care service provider receiving such an overpayment or erroneous payment shall, upon discovery or notice thereof, return such payment to the Plan within 30 days of discovery or demand. Neither the Plan nor the Plan Administrator shall have any obligation to make any other payment of the bill prior to refund by the health care provider, Employee or Dependent. A health care provider may not apply an erroneous or duplicate payment to another bill balance or any other Dependent. The Plan Administrator shall have the exclusive right to choose who will repay it for an overpayment or erroneous payment (i.e., including but not limited to the Employee, Dependent, health care service provider or another health benefit plan). If the Plan elects to seek refund from the Employee or Dependent, recovery of the overpaid amount shall, at the Plan Administrator's option, be reimbursed in a lump-sum, time payments or deducted from future claims presented for processing.

Health care service providers accepting payment for services from the Plan, in consideration of such payments, further agree to submit claims for reimbursement in strict accord with their state's health care practice acts, ICD-10, or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator.

Any claims not paid in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur a pre-judgment interest rate of 1 ½% per month. The Plan shall be entitled to litigation costs and actual attorney fees in the event it becomes necessary to institute suit to recover duplicate or erroneous payments or payments of improperly billed charges.

Conformity With Applicable Law

This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document.

Clerical Error

Clerical errors, such as inaccurate transcription of premiums, Effective Dates, termination dates, or such as erroneous mailings, shall not change the rights or obligations of any party under the Plan and shall not operate to grant additional benefits to Plan Members.

Fraud

The following actions by any Plan Member, or a Plan Member's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for that Plan Member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Plan Member in the Plan;
2. Attempting to file a claim for a Plan Member for services which were not rendered or drugs or other items that were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

No Waiver

The failure of the Plan Administrator to strictly enforce any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Plan Administrator reserves the right to strictly enforce each and every provision of this Plan at any time regardless of the prior conduct of the Plan Administrator and regardless of the similarity of the circumstances or the number of prior occurrences.

Plan Contributions

The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed by each Plan Member.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be free to determine the manner and means of funding the Plan. The amount of the Plan Member's contribution will be determined from time to time by the Plan Administrator.

Booklets

The Plan Administrator has issued to each Employee an individual booklet, which summarizes the benefits to which the person is entitled, to whom benefits are payable, and the provisions of the Plan affecting the Plan Members.

Entire Plan

The Plan including any amendments, the Schedule of Coverage, any other applicable schedules, the attached papers, and the individual applications, if any, of the Employees and eligible Dependents, constitute the entire description of benefits between the parties and any statement made by the Employer or by any Employee shall not, in any way, change such benefits.

All statements made by the Employer or by a Plan Member shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this Plan or be used in defense of a claim unless they are contained in writing and signed by the Employer or by the Plan Member, as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such contest.

Plan Modification and Amendment

The City Manager of the Company shall be empowered to amend this Plan or any benefit under this Plan at any time by a written instrument signed by the City Manager. An increase or decrease in Plan benefits will become effective as of the date specified in the Plan or in an applicable amendment.

The Plan will furnish each Plan Member with a summary of any material reductions in covered services or benefits not later than 60 days after the effective date of such change.

Plan Termination

The City Manager of the Company may terminate the Plan at any time. Upon termination, the rights of the Plan Members to benefits are limited to claims incurred and due up to the date of termination. Any termination of the Plan will be communicated to Plan Members.

Assignment

The Plan Member's benefit payments may not be assigned except by consent of the Company to other than suppliers of medical services.

Automatic Assignment

All medical/**dental** expense benefits payable under this Plan shall be paid to the medical/**dental** service provider, unless the claimant furnishes proof of payment of the medical/**dental** expenses at the time the claim is filed with the Claims Administrator, in which case the benefits shall be paid to the claimant.

Physical Examination

The Plan at its own expense shall have the right and opportunity to examine any Plan Member, whose Injury or Sickness is the basis of a claim, as often as it may reasonably require while a claim is pending.

Disclosure Of Electronic Protected Health Information (“Electronic PHI”) To The Plan Sponsor For Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

1. Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI; and
4. Report to the Plan any Security Incident of which it becomes aware.

Any terms not otherwise defined shall have the meanings set forth in the Security Standards.

Privacy Standards

1. Disclosure of Summary Health Information to the Plan Sponsor.

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

“Summary Health Information” may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

2. Disclosure of Protected Health Information (“PHI”) to the Plan Sponsor for Plan Administration Purposes.

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

- a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);
- b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
- d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- e. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);
- f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

- g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
- h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);
- i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- j. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - i. The following Employees or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

HR Department
City Manager
 - ii. The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
 - iii. In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Document relating to use and disclosure of PHI, the Plan Sponsor shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

“Plan Administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan Administration” functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

3. Disclosure of Certain Enrollment Information to the Plan Sponsor.

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan.

4. Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage.

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

5. Other Disclosures and Uses of PHI.

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

SECTION L

SUBROGATION/RIGHT OF REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Members, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Member(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Plan Member(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Plan Member(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Member(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Plan Member(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Plan Member shall be a trustee over those Plan assets.

In the event a Plan Member(s) settles, recovers, or is reimbursed by any Coverage, the Plan Member(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Member(s). If the Plan Member(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Member(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Member(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Plan Member(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Member(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Plan Member(s) fails to so pursue said rights and/or action.

If a Plan Member(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Member(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Plan Member is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Plan Member is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Plan Member(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Plan Member(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

the Plan Member(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Member's/Plan Members' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Member(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, without regard to whether the Plan Member(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Member's/Plan Members' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Plan Member are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Plan Member's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Plan Member is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Member(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Member(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, disease or disability.

Plan Member is a Trustee Over Plan Assets

Any Plan Member who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Plan Member understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Plan Member is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Member obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Plan Member disputes this obligation to the Plan under this section, the Plan Member or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Plan Member, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

If at the time of Injury, Sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Plan Member(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Member(s), such that the death of the Plan Member(s), or filing of bankruptcy by the Plan Member(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Plan Member(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Plan Member(s) and all others that benefit from such payment.

Obligations

It is the Plan Member's/Plan Members' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.

7. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Member may have against any responsible party or Coverage.
8. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
9. In circumstances where the Plan Member is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Member obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
10. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Plan Member over settlement funds is resolved.

If the Plan Member(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Plan Member(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Member(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Member's/Plan Members' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Plan Member and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Plan Member's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Plan Member(s) in an amount equivalent to any outstanding amounts owed by the Plan Member to the Plan. This provision applies even if the Plan Member has disbursed settlement funds.

Minor Status

In the event the Plan Member(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

SECTION M

CLAIM/APPEAL PROCEDURES

The procedures outlined below must be followed by Plan Members ("claimants") to obtain payment of health benefits under this Plan.

All claims and questions regarding health claims should be directed to the Claims Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the claimant is entitled to them. The responsibility to process claims in accordance with the Master Plan Document and summary plan description may be delegated to the Claims Administrator; provided, however, that the Claims Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion. The Plan Administrator has retained the services of an independent third party administrator, EBSO, Inc. ("Claims Administrator") to provide technical services, including the processing of claims.

Each Plan Member claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator, in its sole discretion may require, written proof that the expenses were Incurred and that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the claimant has not Incurred a Covered Expense or that the benefit is not covered under the Plan, or if the claimant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

Under the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

Definitions

Words which are capitalized in this document are either defined below or in the Master Plan Document (see Definitions of General Terms, General Information and General Provisions) and summary plan description.

Pre-service Claims:

A "Pre-service Claim" arises when there is a claim for a benefit under the Plan and the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A "Pre-service Urgent Care Claim" arises when there is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant

or the claimant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

It is important to remember that, if a claimant needs medical care for a condition which could seriously jeopardize his life, there is no need to contact the Plan for prior approval. The claimant should obtain such care without delay.

Further, if the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Concurrent Claims:

A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the claimant requests extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Post-service Claims:

A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed

Health claims must be filed with the Claims Administrator within six months of the date charges for the service were incurred. However in no event, except in the absence of legal capacity, will claims be accepted later than 12 months from the date the charge in question was incurred. Charges are considered incurred when treatment or care is given or supplies are provided. **Claims filed later than that date shall be denied.**

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Utilization Review Organization in accordance with the Plan's Utilization Review procedures.

However, a Post-service Claim is considered to be filed when the following information is received by the Claims Administrator, together with a Form HCFA, Form UB92 or Form ADA:

1. The date of service;
2. The date the Injury or Sickness began;
3. The name, address, telephone number and tax identification number of the provider of the services or supplies;
4. The place where the services were rendered;
5. The diagnosis and procedure codes;
6. The amount of charges;
7. The name of the Plan and Plan ID #;
8. The name and home address of the Employee;
9. The Employee's social security number;
10. The name and home address of the patient; and
11. The patient's social security number.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Utilization Review Organization will determine if enough information has been submitted to enable proper consideration of the Pre-service Claim or Pre-service Urgent Claim. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the post-service claim. If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within 45 days (or by the Utilization Review Organization within 48 hours in the case of Pre-service Urgent Care Claims) from receipt by the claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

NOTE: The Plan does not consider inquiries about benefits, eligibility or the circumstances under which benefits might be paid, to be claims. An inquiry does not become a claim unless the proper claim procedure is followed. Further, questions concerning eligibility for benefits, such as calls from providers of medical services, are NOT ever considered claims.

Timing of Claim Decisions

The Plan Administrator shall notify the claimant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

Pre-service Urgent Care Claims:

If the claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim. The claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded the claimant to provide the information.

Pre-service Non-urgent Care Claims:

If the claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the claimant (if additional information was requested during the extension period).

Concurrent Claims:

Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The claimant will be notified sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving Urgent Care and decided within the Urgent Care timeframe.

Request by Claimant Involving Non-urgent Care. If the Plan Administrator receives a request from the claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

Post-service Claims:

If the claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If the claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the claimant will be notified of the determination by a date agreed to by the Plan Administrator and the claimant.

Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service Urgent Care Claims.

Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a claimant with a notice, either in writing or electronically (or, in the case of Pre-service Urgent Care Claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), containing the following information:

1. A reference to the specific portion(s) of the Master Plan Document and summary plan description upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the claimant's right to bring a civil action following an adverse benefit determination on final review;
5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;
6. The identity of any medical, dental or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the claimant, free of charge, upon request);
8. In the case of denials based upon a medical judgment (such as whether the treatment is Medical Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided to the claimant, free of charge, upon request; and
9. In a claim involving Urgent Care, a description of the Plan's expedited review process.

Requested copies will be provided to the claimant within a reasonable period of time, not to exceed 30 days from the date the Plan receives the written request for copies.

Appeal of Adverse Benefit Determinations – Internal Review

A. Procedures for Review of Adverse Benefit Determinations

In cases where a claim for benefits is denied, in whole or in part, and the claimant believes the claim has been denied wrongly, the claimant may appeal the denial and review relevant documents. The claims procedures of this Plan provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. Claimants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination. If the claimant does not appeal on time, he/she will lose the right to file suit in court and will have failed to exhaust the Plan's internal administrative appeal procedures, which is generally a prerequisite to bringing suit;
2. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. For a review that is independent from the initial adverse benefit determination and is conducted by an appropriate named fiduciary of the Plan who is not the same individual who decided the claimant's initial adverse benefit determination and who is not also that individual's subordinate;
4. For a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
5. That, if an adverse benefit determination is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with an independent health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is not the same person as the health care professional consulted in connection with the initial adverse benefit determination;
6. For the identity of medical/vocational experts consulted in connection with the appeal, even if the Plan did not rely upon their advice; and
7. In an Urgent Care Claim, for an expedited review process pursuant to which:
 - a. A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

- b. All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

B. Requirements for Appeal

The claimant must file the appeal in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) within 180 days following receipt of the notice of an initial adverse benefit determination. For Pre-service Urgent Care Claims, if the claimant chooses to orally appeal, claimant may telephone: Appeal Dept. EBSO, Inc. at 800-558-7798. To file an appeal in writing, the claimant's appeal must be addressed as follows and mailed and/or faxed to the following number: *Attention: Appeal Dept. c/o EBSO, Inc. 215 Stanford Parkway, Findlay, OH 45840. Fax (419) 423-5834.*

It shall be the responsibility of the claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee;
2. The name of the claimant;
3. The Employee's social security number;
4. The claimant's social security number;
5. The group name and identification number;
6. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories which support this claim if the claimant fails to include them in the appeal;**
7. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
8. Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.

If the claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

C. Notification of Benefit Determination on Review

The Plan Administrator shall notify the claimant of the Plan's benefit determination on review within the following timeframes:

Pre-service Urgent Care Claims: As soon as possible, taking into account the medical

exigencies, but not later than 72 hours after receipt of the appeal.

Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – Pre-service Urgent, Pre-service Non-urgent or Post-service.

Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

D. Manner and Content of Notification of Adverse Benefit Determination on Review.

The Plan Administrator shall provide a claimant with notification, with respect to Pre-service Urgent Care Claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Master Plan Document and summary plan description on which the denial is based;
3. The identity of any medical, dental or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided free of charge upon request;

7. A description of any available External Review process and how to initiate an External Review;
8. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office or the Plan Administrator."

If, for any reason, the claimant does not receive a written response to the appeal within the appropriate time period set forth above, the claimant may assume that the appeal has been denied and the Plan's internal review procedures have been exhausted.

Appeal of Adverse Benefit Determinations – External Review

A. Overview

If the claim is denied, the claimant may be eligible to have his/her claim reviewed by an Independent Review Organization (IRO) pursuant to a process called "External Review." Generally, External Review is available only after the claim denial has been upheld after the final level of appeal under the Plan. The claimant may, however, in limited circumstances have the right to have the claim reviewed by an IRO prior to exhausting the Plan's appeal process. See **Expedited External Review** for further details.

B. Request for Review

External Review is available only for medical claims (excluding dental and vision) that involve medical judgment (including, for example, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination as to whether a treatment is experimental or investigational) and for rescissions of coverage (i.e. retroactive cancellations of coverage because of the Plan Member's fraud or intentional misrepresentation of a material fact regarding eligibility for coverage).

Federal government agency guidance may further limit or broaden the scope of External Review. The Plan will provide an External Review process in accordance with applicable guidance.

A request for External Review must be filed in accordance with the instructions contained in the claimant's appeal denial notice and must be received not later than four months after the date he/she receives the appeal denial notice. If there is no corresponding date four months after the date of the appeal denial notice, then the request must be filed by the first day of the fifth month following receipt of the notice. For example, if the date of the denial notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

C. Preliminary Review

Within five business days after receiving the claimant's External Review request, the Plan Administrator will complete a preliminary review to determine whether his/her request is complete and eligible for External Review. That preliminary review will determine: whether the claimant was covered under the Plan at the time the item or service was requested or provided; whether the final denial of his/her appeal related to the claimant's failure to meet the Plan's eligibility requirements; whether the claimant exhausted the Plan's internal appeal process (or are not required to exhaust the process); and whether the claimant has provided all the information and forms required to process an External Review.

Within one business day after the completion of the preliminary review, the Plan Administrator will notify the claimant of one of the following:

1. That his/her request is complete, but she/he is not eligible for external review. This notice will state the reasons for the ineligibility and provide contact information for the Employee Benefits Security Administration.
2. That his/her request is incomplete, but may still be eligible for external review. This notice will describe the information or materials needed to complete the request. The claimant will be permitted to provide the required information by the later of: (a) the last day of the four month filing period or (b) 48-hours after receipt of the notice.
3. That his/her request is complete and eligible for external review.

D. Referral to IRO

If the claimant's request for External Review is complete and eligible, the Plan Administrator will assign a qualified IRO to conduct the External Review and within five business days after making the assignment will provide the IRO with the documents and information the Plan Administrator considered in making its final appeal denial.

The claimant will have at least 10 days to submit additional information to the IRO. If the claimant submits additional information, the IRO will send that information to the Plan and the Plan may reconsider its determination. If the Plan decides, on reconsideration, to reverse its benefits denial and provide coverage or payment, then the external review can be terminated.

If the Plan does not reverse its determination, the IRO will review all of the information and documents timely received. In reaching a decision the IRO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeal process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate will

consider the following in reaching a decision: the claimant's medical records; the attending health care professional's recommendation; reports from the appropriate health care professionals and other documents submitted by the Plan Administrator, the claimant's treating provider; the terms of the Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan; appropriate practice guidelines; any applicable clinical review criteria developed and used by the Plan; and the opinion of the IRO's clinical reviewer(s).

The IRO must provide written notice to the claimant and the Plan Administrator of the final External Review decision within 45 days after the IRO receives the request for External Review. If the IRO reverses the Plan's determination, the Plan must immediately provide coverage or payment for the claim.

E. Expedited External Review

Under the following circumstances, the claimant may be eligible to file for an expedited External Review:

1. If the claimant receives a claim denial that involves a medical condition for which the timeframe for completion of an expedited internal appeal with the Plan Administrator would seriously jeopardize the claimant's life or health, or that would jeopardize the claimant's ability to regain maximum function, and the claimant has filed a request for an expedited internal appeal; or
2. If the claimant receives a final appeal denial from the Plan Administrator and: he/she has a medical condition for which the timeframe for completion of a standard external appeal would seriously jeopardize his/her life or health, or would jeopardize his/her ability to regain maximum function; or if the final claim denial concerns an admission, availability of care, continued stay, or health care item or service for which the claimant has received emergency services but have not been discharged from a facility.

Immediately upon receipt of the request for an expedited External Review, the Plan Administrator will complete a preliminary review of the claimant's request in order to determine his/her eligibility for expedited External Review. Immediately after completion of the preliminary review, the Plan Administrator will issue the claimant a written notification of his/her eligibility for expedited External Review. If the claimant's request is complete but not eligible for External Review, the notice will include the reasons for ineligibility. If the claimant's request is incomplete, the notice will describe the information or materials needed to make the request complete and the claimant will have an opportunity to complete the request.

Upon a determination that a request is eligible for expedited External Review, the Plan Administrator will assign an IRO for review and transmit all necessary documents and

information to the IRO. The IRO must provide notice, to the claimant and the Plan Administrator of the final External Review decision as expeditiously as possible, but in no event later than 72 hours after the IRO receives the request for the expedited External Review.

All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.

Appointment of Authorized Representative

A claimant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the claimant must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. **In the event a claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the claimant, unless the claimant directs the Plan Administrator, in writing, to the contrary.**

**MASTER PLAN DOCUMENT AMENDMENT #1
(Dental Plan)**

Effective July 1, 2019, the Master Plan Document and Summary Plan Description for City of San Luis – Dental Plan is hereby amended as follows:

SCHEDULE OF COVERAGE, is hereby deleted and replaced with Attachment A

DEFINITIONS OF GENERAL TERMS, EMPLOYEE, is hereby deleted replaced with the following:

EMPLOYEE means an Employee of the Employer who is regularly scheduled to actively perform the principle duties of his/her occupation a minimum of 30 hours per week, and who is enrolled and eligible for coverage under the Plan. Employee also included Council Members who are working a minimum of 20 hours per month.

Part-time, seasonal, temporary and retired employees are not eligible for coverage under the Plan. Employee does not include the following:

1. a self-employed individual as described in Section 401 (c) of the Code, including, but not limited to, a sole proprietor if the Employer is a sole proprietorship, a person owning more than 2% of the Employer if it is a Subchapter S corporation, a partner of the Employer if it is a partnership, and a member of the Employer if it is a limited liability company and the members are treated as partners for income tax purposes;
2. an employee who is a spouse, child, grandchild, or parent of a person owning more than 2% of the Employer if it is a Subchapter S corporation;
3. any individual included within a unit of employees covered by a collective bargaining unit unless such agreement expressly provides for coverage of the Employee under the Plan;
4. any individual who is a nonresident alien and receives no earned income from the Employer from sources within the United States;
5. any individual who is a leased employee as defined in Section 414(n)(2) of the Code;
6. any individual who performs services for the Employer through, and is paid by, a third-party (including but not limited to an employee leasing or staffing agency) even if such individual is subsequently determined to be a common law employee of the Employer; or
7. any individual who performs services for the Employer pursuant to a contract or agreement (whether verbal or written) which provides that such individual is an independent contractor or consultant, even if such individual is subsequently determined to be a common law employee of the Employer.

DENTAL BENEFITS, is hereby deleted and replaced with the following:

DENTAL BENEFITS

Covered Dental Expenses

The Plan will pay benefits for Covered Expenses Incurred by a Plan Member for the following dental services, only when performed by a Dentist or a Dental Hygienist, or other dental provider working under the direction and supervision of the Dentist. The payment is subject to the General Limitations and Exclusions and all other provisions of the Plan.

Class I Services –Preventive and Diagnostic Services

- D0120 Follow up exam every 6 months
- D0140 Emergency exam
- D0145 Oral evaluation for a patient under age 3/counseling with primary caregiver
- D0150 Initial oral exam
- D0160 Detailed and extensive oral evaluation-problem focused, by report
- D0170 Re-evaluation limited problem focused (establish patient)
- D0210 Intraoral complete series (including Bitewings)
- D0220 Intraoral single/firts film 1
- D0230 Intraoral periapical each film
- D0240 Intraoral occlusal film each
- D0270 Bitewing single film
- D0272 Bitewings - two films
- D0273 Bitewings - three films
- D0274 Bitewings - four films
- D0277 Vertical bitewings
- D0330 Panoramic radiographic image
- D0431 Adjunctive pre-diagnostic test (mucosal lesions)
- D1351 Appl sealant per tooth
- D1110 Adult prophylaxis
- D1120 Child prophylaxis
- D1208 Topical application of fluoride
- D2910 Re-cement inlay
- D2920 Re-cement crown
- D2940 Sedative filling
- D2950 Core buildup, including any pins
- D9223 Deep sedation/general anesthesia-each additional 15 minutes
- D9230 Analgesia, anxiolysis, inhalation of nitrous oxide
- D9910 Application of desensitizing medicament

Class I Services –Limitations

- Teeth cleaning – limited to 2 times per Calendar Year
- Exams – limited to 2 times per Calendar Year
- Dental x-rays
 - Full or Panoramic – limited to once in any 36 consecutive month period
 - Bitewings films, maximum of 4 films per visit – limited to 2 sets of x-rays per Calendar Year
 - Vertical bitewing x-rays – limited to 1 set every 3 years

- Fluoride treatments – limited to children under age 16 and to 1 treatment per Calendar Year
- Sealants – limited to unrestored permanent molars of Plan Members under 16 years of age and to one treatment per tooth in any 36 consecutive months
- Office visits, during regular hours – problem focus exams – limited to 2 visits per Calendar year

Class II Services – Basic Services

- D0322 Tomographic survey
- D0480 Accession of exfoliative cytologic smears (written report)
- D1510 Space maintainer - fixed bilateral
- D1515 Space maintainer - fixed unilateral
- D2140 Amalgam one surf/permanent or primary
- D2150 Amalgam two surf/permanent or primary
- D2160 Amalgam three surf/permanent or primary
- D2161 Amalgam four surf/permanent or primary
- D2330 Composite resin one surface anterior
- D2331 Composite resin two surface anterior
- D2332 Composite resin three surface anterior
- D2335 Composite resin four or more surfaces
- D2390 Resin based composite crown, anterior
- D2391 1 surface resin based composite
- D2392 2 surface resin based composite
- D2393 3 surface resin based composite
- D2394 4 or more surface resin based composite
- D2954 Post & core
- D2957 Each additional prefabricated post- same tooth
- D2960 Labial veneer (resin laminate)- chairside
- D2961 Labial veneer (resin laminate)- laboratory
- D2962 Labial veneer (porcelain laminate)- laboratory
- D3110 Pulp cap - direct (excluding final restoration)
- D3120 Pulp cap - indirect (excluding final restoration)
- D3220 Therapeutic pupotom (excluding final restoration)
- D3221 Pulpal debridement primary and permanent
- D3230 Pulpal therapy - anterior, primary tooth
- D3240 Pulpal therapy - posterior, primary tooth
- D3310 Anterior root canal
- D4211 Gingivectomy/plasty - one to three contiguous teeth, per quad
- D4240 Gingival flap procedure - four or more contiguous teeth or tooth per quad
- D4341 Periodontal scaling & root planning per quadrant
- D4342 Periodontal scaling and root planing - one to three teeth per quad.
- D4355 Full mouth debridement
- D4910 Periodontal maintenance, following active therapy
- D5650 Add tooth to existing partial denture
- D5660 Add clasp to existing partial denture
- D5710 Rebase complete lower denture

- D5711 Rebase complete upper denture
- D5720 Rebase upper partial denture
- D5721 Rebase lower partial denture
- D5730 Reline complete upper denture (chairside)
- D5731 Reline complete lower denture (chairside)
- D5740 Reline upper partial denture (chairside)
- D5741 Reline lower partial denture (chairside)
- D6930 Recement fixed partial bridge
- D7111 Extraction baby tooth
- D7140 Extraction erupted tooth (adult)
- D7210 Surgical removal erupted tooth
- D7220 Soft tissue impaction
- D7230 Partially bony impaction
- D7250 Surgical removal of residual tooth roots (cutting proc.)
- D7910 Suture recent small wound (5cm)
- D7950 Osseous, osteo perio graft
- D7960 Frenulectomy

Class III Services – Major Dental Repair Services

- D2642 Onlay - porcelain/ceramic - 2 surface
- D2643 Onlay - porcelain/ceramic - 3 surface
- D2644 Onlay - porcelain/ceramic - 4 surface
- D2722 Crown - resin with noble metal
- D2740 Crown - porcelain/ceramic
- D2750 Crown - porcelain w/gold
- D2751 Crown - porcelain fused to predominantly base metal
- D2752 Crown - porcelain fused to noble metal
- D2790 Gold (full cast) crowns
- D2799 Provisional crown-temporary restoration of least six months
- D2930 Stainless crown (primary)
- D2931 Stainless steel crown-per tooth
- D2932 Prefabricated resin crown
- D3320 Bicuspid root canal
- D3330 Root canal therapy - molar
- D3346 Retreatment root canal anterior (one root)
- D3347 Retreatment root canal bicuspid (two roots)
- D3348 Retreatment root canal molar (three roots)
- D3410 Apicoectomy (per tooth) anterior
- D3421 Apicoectomy/periradicular surgery - bicuspid
- D3425 Apicoectomy/periradicular surgery - molars
- D3426 Apicoectomy/periradicular surgery - (each additional root)
- D4210 Gingivectomy/plasty - four or more contiguous teeth, per quad
- D4241 Gingival flap procedure -one to three contiguous teeth or tooth per quad
- D4249 Clinical crown lengthening - hard tissue
- D4260 Osseous surgery- four or more contiguous teeth or tooth
- D4261 Osseous surgery- one to three contiguous teeth or tooth
- D4263 Bone replacement graft-retained natural tooth-first site in quad.

- D4264 Bone replacement graft - multisite
- D4273 Subepithelial tissue graft procedure subepithelial
- D4321 Provisional splinting-extra coronal
- D5110 Complete denture, upper - once every 5 years
- D5120 Complete denture, lower - once every 5 years
- D5130 Immediate upper dentures - lifetime benefit
- D5140 Immediate lower dentures - lifetime benefit
- D5211 Maxillary partial denture/resin base
- D5212 Mandibular partial denture/resin base
- D5213 Upper partial denture/metal frame work w/resin
- D5214 Lower partial denture/metal frame work w/resin
- D5281 Remove unilat part/one piece cast metal
- D5820 Interim partial denture (upper)
- D5821 Interim partial denture (lower)
- D6242 Pontic - porcelain fused to noble metal
- D6740 Crown - porcelain
- D6750 Crown - porcelain fused to high noble metal
- D6751 Crown - porcelain fused to predominantly base metal
- D6752 Crown - porcelain fused to noble metal
- D7240 Completely bony impaction
- D7241 Removal of impacted tooth - completely bony
- D7272 Surgical tooth transplantation
- D7286 Biopsy of oral tissue - soft
- D7472 Removal of torus palatinus
- D7473 Removal of torus mandibular
- D7485 Surgical reduction of osseous tuberosity

Class III Services –Limitations

- Denture repairs, adjustments, relines or rebase – limited to adjustments made more than 6 months after the initial installation. Rebase is limited to once per 36 consecutive month period. Reline is limited to once per 12 consecutive month period.
- Complete and partial dentures. Immediate dentures are limited to one set per Lifetime.

NOTE: The Plan covers the replacement of an existing denture or bridge only if the existing denture or bridge is unserviceable and cannot be made serviceable. The Plan pays the benefit level that applies to the cost of services necessary to make the appliances serviceable. The plan will cover replacement of prosthodontic appliances only if at least 5 years have elapsed since the date of the initial insertion of that appliance.

Class IV Services – Orthodontic Services.

NOTE: Dependent children must be covered under the Dental Plan for twelve (12) consecutive months before orthodontia benefits are available.

- D0340 cephalometric film
- D0350 panoramic film
- D0470 diagnostic cast
- D8030 limited orthodontic treatment of the adolescent dentition
- D8670 periodic orthodontic treatment visit cast part of contract

Any other Class I, II or III services that are performed in connection with orthodontic treatment shall be payable under their appropriate payment percentage and not included under the orthodontic limitations and/or payment percentages.

Accepted By:

Name:	Title	Date
For: City of San Luis		

SCHEDULE OF COVERAGE

NOTE: THIS IS ONLY A SUMMARY, SPECIFIC SERVICES AND SUPPLIES MAY BE SUBJECT TO OTHER DEDUCTIBLES, COPAYS, PAYMENT PERCENTAGES, MAXIMUM BENEFIT PAYMENTS, USUAL, CUSTOMARY AND REASONABLE FEES AND/OR EXCLUSIONS AND LIMITATIONS.

NOTE: Benefits under this Plan will be paid only if the Plan Administrator decides in his/her discretion that the individual is entitled to them.

DENTAL BENEFITS

Calendar Year Deductible	
Class I Services	NONE
Class II, III and IV Services	
Individual	\$25
Family	\$50
Payment Percentages after Deductible is met	
Class I Services – Diagnostic and Preventive Care	100%
Class II Services - Basic Services	80%
Class III Services - Major Services	50%
Class IV Services – Orthodontics	50%
Maximum Benefits	
Per Calendar Year for Class I, II & III Services, combined	\$2,000
Per Lifetime for Class IV Services	\$2,000

If Covered Services are rendered in Mexico and in the United States in one Calendar Year, the Maximum Calendar Year benefit paid by the Dental Plan is \$2,000. Only \$1,000 of the Covered Services can be rendered in Mexico in the Calendar Year, and a Siarmed Network Provider must be utilized for those Covered Services provided in Mexico.

If Orthodontia treatments that are Covered Services have started in Mexico, the treatment must be completed in Mexico. Orthodontia treatment completed in the United States will not be a Covered Service if the treatment started in Mexico.

NOTE: Orthodontic Services are **LIMITED** to Dependent children less than 19 years of age. Dependent children must be covered under the Plan for 12 consecutive months before orthodontic services are available.

**City of San Luis
EMPLOYEE BENEFIT TRUST – Mexico Coverage**

**SUMMARY PLAN DESCRIPTION AND
PLAN DOCUMENT**

EBSO GROUP NUMBER: SLS001

Effective: July 1, 2018

TABLE OF CONTENTS

SECTION A	2
INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION	2
<i>Introduction and Purpose</i>	2
<i>General Plan Information</i>	3
SECTION B	5
SCHEDULE OF COVERAGE	5
SECTION C	9
DEFINITIONS OF GENERAL TERMS.....	9
SECTION D	28
ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE	28
EMPLOYEE ELIGIBILITY DATE	28
EMPLOYEE EFFECTIVE DATE OF COVERAGE	28
DEPENDENT ELIGIBILITY DATE	28
DEPENDENT EFFECTIVE DATE OF COVERAGE	29
CHANGE IN STATUS	29
SPECIAL ENROLLMENT PERIOD.....	30
OPEN ENROLLMENT PERIOD	31
CHOOSING PLAN OPTIONS.....	32
TERMINATION OF INDIVIDUAL COVERAGE.....	32
SECTION E.....	35
CONTINUATION OF COVERAGE UPON INDIVIDUAL TERMINATION (COBRA).....	35
SECTION F	47
UNIFORMED SERVICES CONTINUATION AND REINSTATEMENT PROVISION	47
SECTION G	49
GENERAL LIMITATIONS AND EXCLUSIONS	49
SECTION H	61
PRE-CERTIFICATION	61
SECTION I.....	62
COMPREHENSIVE MAJOR MEDICAL BENEFITS	62
COVERED EXPENSES	62
SECTION J	78
ANNUAL OUT-OF-POCKET MAXIMUM BENEFIT	78
SECTION K	79
SIARMED	79
<i>Responsibility for use of Siarmed</i>	79
SECTION L.....	80
CARE PROVIDED BY THE UNITED STATES GOVERNMENT	80
COORDINATION OF BENEFITS	80
EFFECT ON BENEFITS	81

SECTION M	85
MEDICARE SELECTION PROVISION	85
SECTION N	86
GENERAL PROVISIONS	86
<i>The Plan and The Master Plan Document</i>	86
<i>Plan Administrator</i>	86
<i>Named Fiduciary</i>	86
<i>Claims Administrator</i>	86
<i>The Plan Is Not An Employment Contract</i>	87
<i>Exchange Of Information</i>	87
<i>Alternative Treatment</i>	87
<i>Free Choice of Physician</i>	88
<i>Qualified Medical Child Support Orders (QMCSO)</i>	88
<i>Other Service Plan Contracts</i>	89
<i>Worker's Compensation Notice</i>	89
<i>Erroneous Payment Refund Provision</i>	89
<i>Conformity With Applicable Law</i>	90
<i>Clerical Error</i>	90
<i>Fraud</i>	90
<i>No Waiver</i>	91
<i>Plan Contributions</i>	91
<i>Plan Modification and Amendment</i>	92
<i>Automatic Assignment</i>	92
<i>Physical Examination</i>	93
<i>Disclosure Of Electronic Protected Health Information ("Electronic PHI") To The Plan Sponsor For Plan</i>	
<i>Administration Functions</i>	93
<i>Privacy Standards</i>	93
SECTION O	97
SUBROGATION/RIGHT OF REIMBURSEMENT	97
SECTION P	104
CLAIM/APPEAL PROCEDURES	104

ESTABLISHMENT OF THE MASTER PLAN DOCUMENT

Effective July 1, 2018, the Plan Sponsor establishes City of San Luis Employee Benefit Plan – Mexico Coverage (the "Plan") to provide self-funded benefits for its Employees and their Dependents.

This Plan replaces the Plan Sponsor's previous plan of medical and prescription drug benefits. It is the intent of the Plan Sponsor to provide continuous eligibility and coverage from the previous plan to this Plan.

The Plan Sponsor hereby adopts this Plan Document as the written description of the Plan.

Disclaimer Of Claims Administrator

EBSO, Inc. has prepared this document for your review and consideration; however, we are not legal counsel, nor are we in the business of practicing law. As your Plan's fiduciary, you are fully responsible for all legal issues that concern the Plan. If you are not an expert in this area, we urge you to hire an attorney to help you review this Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Date

Signature

Print or Type Name and Title

Witness Signature

Print or Type Witness Name

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Medical and surgical benefits to women who have undergone a mastectomy (a surgical procedure to remove the breast or breast tissue) were expanded under the federal Women's Health and Cancer Rights Act in 1998. The bill has a provision that requires health plans to provide coverage for certain mastectomy related procedures. As a Plan Member, you receive coverage for all stages of reconstruction of the breast on which the mastectomy was performed, breast prosthesis (artificial substitute), and physical complications of mastectomy including lymphedemas, surgery, and reconstruction of the other breast to produce a symmetrical appearance. Treatments are subject to the same Copays and Deductibles (where applicable) as other covered surgical procedures. For more information on Copays and Deductibles for surgical procedures, see the Schedule of Coverage.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

SECTION A

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

City of San Luis, the Employer, has established the City of San Luis Employee Benefit Trust – Mexico Coverage in order to provide comprehensive healthcare benefits for Employees, and their Dependents.

The City of San Luis Employee Benefit Trust – Mexico Coverage is a self-insured public sector plan within the meaning of Arizona Statute 11-981 (hereinafter “Plan”). The Plan is not an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). Any resemblance to an ERISA plan shall not be construed to mean it is an ERISA plan. The Plan is a self-insured medical plan intended to meet the requirements under Sections 105(b), 105(h) and 106 of the Internal Revenue Code of 1986 so the portion of the cost for coverage paid by the Employer is not taxable income to the Employee and any benefits received through the Plan are not taxable income to the Employee. This Plan is a group health plan for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and shall be administered in a manner consistent with HIPAA.

The Plan Sponsor has established the Plan for the benefit of eligible employees and their eligible dependents, on the terms and conditions described herein. The Plan Sponsor’s purpose in establishing the Plan is to help to offset, for eligible Employees, the economic effects arising from a non-occupational Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

This Plan is a non-grandfathered plan under Patient Protection and Affordable Care Act (PPACA) and Health Care and Education Reconciliation Act (HCERA), collectively referred to as Health Care Reform.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain medical expenses. The Plan Document is maintained by the Plan Sponsor and may be inspected at any time during normal working hours by any Plan Member.

The Schedule of Coverage is meant only as a summary of benefits. For more details about the benefits, check the Table of Contents and refer to the specific section in the booklet for complete terms and conditions.

This Plan covers only those expenses incurred in connection with non-occupational injuries or disease.

The Employer has contracted with the Claims Administrator to perform certain consultative and management services related to the Plan. The Employer retains ultimate authority for the Plan.

Certain words in this Plan have precise meanings and will be capitalized and defined in the Definition section or where used in the text, so that you will pay special attention to them.

New Rescission of Coverage Rules. Under this Plan, coverage may be retroactively cancelled or terminated if you act fraudulently or make material misrepresentations of fact. It is your responsibility to provide accurate information and to make accurate and truthful statements including information and statements regarding familial status, age, relationships, etc. In addition, it is your responsibility to update previously provided information and statements. Failure to do so may result in your coverage, including the coverage of those provided coverage through you, being cancelled and such cancellation may be retroactive.

General Plan Information

Name of Plan:	City of San Luis Employee Benefit Trust – Mexico Coverage
Plan Sponsor:	City of San Luis 1090 E. Union Street San Luis, AZ 85349 928-341-8547
Plan Administrator: (Named Fiduciary)	City of San Luis 1090 E. Union Street San Luis, AZ 85349 928-341-8547
Plan Sponsor ID No. (EIN):	86-0376164
Fiscal Year:	January 1 through December 31
Plan Number:	501
EBSO Group Number:	SLS001
Type of Administration:	Self-funded Welfare Plan Prescription Drug Plan

Sources and Methods of
Contributions to the Plan:

The Employer and the Employee share in the cost of the Plan. The Employer's contribution is made from his general assets and the Employee's contribution is made from payroll deductions. The Employer will provide a schedule of the applicable premiums during the initial enrollment, during open enrollment periods, on the Plan's annual renewal date and upon request.

All contributions shall be held in the Trust.

The Plan is "self-insured" which means that benefits are paid with assets from the Trust established by the Employer to pay benefits under the Plan.

Name of Trust

City of San Luis Employee Benefit Trust – Mexico Coverage

Trustees

For current information on Trustees, please refer to the Agreement and Declaration of Trust for City of San Luis Employee Benefit Trust – Mexico Coverage

Claims Administrator:

EBSO, Inc.
215 Stanford Pkwy
Findlay, OH 45840
Phone Number 800-558-7798

Please Note: EBSO, Inc. performs claims processing services pursuant to a contract, it does not insure benefits under the Plan.

Agent for Legal Services:

City of San Luis
1090 E. Union Street
San Luis, AZ 85349
928-341-8547

This document is the Summary Benefit Description (SBD) that describes the basic features of the Plan and how the plan operates.

It is very important to review this document carefully to confirm a complete understanding of the benefits available, as well as responsibilities, under the Plan. The SBD should be read in its entirety because many of its provisions are interrelated.

SECTION B SCHEDULE OF COVERAGE

NOTE: THIS IS ONLY A SUMMARY, SPECIFIC SERVICES AND SUPPLIES MAY BE SUBJECT TO OTHER DEDUCTIBLES, COPAYS, PAYMENT PERCENTAGES, MAXIMUM BENEFIT PAYMENTS, AND/OR EXCLUSIONS AND LIMITATIONS.

NOTE: Benefits under this Plan will be paid only if the Plan Administrator decides in his/her discretion that the individual is entitled to them.

COMPREHENSIVE MAJOR MEDICAL PLAN:

DEDUCTIBLE PER COVERAGE YEAR

There is no Deductible.

ANNUAL OUT-OF-POCKET MAXIMUM PER COVERAGE YEAR

Network:	\$6,250 INDIVIDUAL	Out-of-Network:	\$20,000 INDIVIDUAL
	\$12,500 FAMILY		\$40,000 FAMILY

The Network Annual Out-of-pocket Maximum and the Out-of-Network Annual Out-of-pocket Maximum shall accumulate independently and shall not be used to satisfy each other.

The family Annual Out-of-pocket is the amount contributed toward the Annual Out-of-pocket by two or more family members; provided, the amount contributed toward the family Annual Out-of-pocket by any one family member cannot be more than the individual Annual Out-of-pocket amount.

The Annual Out-of-pocket Maximum **includes** the Coinsurance and Copays. The Annual Out-of-pocket Maximum does **NOT** include any charge in excess of the established plan maximums/limitations and penalties for non-compliance with Plan provisions.

COVERAGE YEAR MAXIMUM PAYMENT AMOUNT	Unlimited

PRE-CERTIFICATION IS REQUIRED FOR THE FOLLOWING SERVICES:

- All non-Emergency Hospitalizations (including skilled nursing facility, inpatient rehabilitation and residential treatment facilities)
- Outpatient surgery
- Special Services, such as podiatry
- CT Scans, Pet Scans and MRIs
- Home Health Care
- Out-of-Network Durable Medical Equipment > \$750 or when rental exceeds 4 months
- Inpatient Rehabilitation/Habilitation services

FOR PRE-CERTIFICATION CALL EBSO-REVIEW, AT 1-800-426-9317. Non-compliance reduces benefits. If a Plan Member does not comply with Pre-certification when required, Covered Expenses will be reduced by a penalty of

**SIARMED: \$250 per service or
Out-of-Network (US providers): 40% of the total cost of the service.**

THE NETWORK IS ADMINISTERED BY: SIARMED

The only Out-of-Network providers covered under this Plan are United States providers. All other Out-of-Network providers are NOT covered except in cases of an Emergency.

The Plan will at all times be in compliance with PPACA rules and regulations. PPACA requires that benefits that are offered by the Plan that are “Essential Health Benefits” as defined by the United States Department of Health And Human Services may not be restricted to less than a certain annual amount. If a major medical benefit of the Plan has a plan maximum below that amount, the Plan will continue to pay benefits for the Essential Health Benefit components of that benefit even though such payments would exceed the plan maximum for that benefit, but only until the Coverage Year Maximum Payment Amount of the Plan is paid.

Benefit Description	Mexico Coverage SIARMED - Plan pays	Out-of-Network – US Healthcare Providers only -Plan Pays	Additional Limitations and Explanations
Ambulance Services -Air and Ground	Not available	50%	
Dental Hospitalization and Dental Services Office Visits	100% after a \$25 Copay per visit	50%	
Durable Medical Equipment, Prosthetics, Orthotics and Disposable Supplies	100% after a \$5 Copay per visit	Hearing aids: 80% All other: 50%	Hearing aids are LIMITED to one per Coverage Year and only covered in US. In network covered services only include: • Nebulizer • Breast pump
Emergency Services and Urgent Care Services			In an Emergency, as defined by the Plan, Out-of-Network Covered Expenses will be paid at the Siarmed level.
Emergency visit	100% after a \$250 Copay per visit	100% after a \$250 Copay per visit	Copay is waived if hospitalized and benefits revert to applicable inpatient hospital benefit.
Urgent Care	100% after a \$20 Copay per visit	50%	
Home Health Care	Not available	50%	LIMITED to a maximum of 60 visits per Coverage Year.
Inpatient Hospital Services (Non- Emergency)/Outpatient Hospital			
Visits for more than 12 hours	100% after a \$50 Copay per visit	50%	
Outpatient surgery (less than 12 hours)	100% after a \$25 Copay per visit	50%	

Benefit Description	Mexico Coverage SIARMED - Plan pays	Out-of-Network – US Healthcare Providers only -Plan Pays	Additional Limitations and Explanations
Inpatient and Outpatient Physician Services			
Primary Care Physician/Specialist Office Visits (includes lab and X-ray)	100% after a \$5 Copay per visit	50%	
Inpatient Visit	100%	50%	
Surgery (Physician's office)	100%	50%	
Surgery (other)	100%	50%	
Physician Services – Pathology, Anesthesiology , or Radiology	100%	50%	
Maternity			
Prenatal visits			
Initial visit	100% after a \$5 Copay per visit	50%	
All other visits	100%	50%	
Hospital Services	100% after a \$50 Copay per visit	50%	
Birthing Centers	Not available	50%	
Mental/Nervous Disorders and/or Substance Abuse			
Inpatient treatment			
Visits for more than 12 hours	100% after a \$50 Copay per visit	50%	
Visits for less than 12 hours	100% after a \$25 Copay per visit	50%	
Outpatient treatment	100% after a \$5 Copay per visit	50%	

Benefit Description	Mexico Coverage SIARMED - Plan pays	Out-of-Network – US Healthcare Providers only -Plan Pays	Additional Limitations and Explanations
Outpatient Diagnostic Tests			
Complex - MRI, CT, PET Scans	100% after a \$25 Copay per visit	50%	
Other X-rays and Laboratory tests	100% after a \$5 Copay per visit	50%	
Outpatient Prescription Drugs			
Generic Drugs	100% after a \$3 Copay per visit	50%	
Name Brand Drugs	100% after a \$6 Copay per visit	50%	
Preventive Care Services			Refer to benefit section for more information on Preventive Services. Includes prescription contraceptives. Cost sharing will apply to a brand name contraceptive if a generic version is available and just as effective and safe.
Pediatric and Adult Preventive Care	100%	50%	
Immunizations, inoculations, vaccinations	100%	50%	
Sterilization – limited to Employee and covered Spouse only	100%	50%	
Rehabilitation and Habilitation Services	100% after a \$5 Copay per visit	50%	Siarmed covered services in Mexico include physical and speech therapy only. Out-of-Network: Speech, occupational, and physical therapies covered at US providers only.
Skilled Nursing Facility	Not available	50%	LIMITED to a maximum of 90 days per Coverage Year.
All other Covered Expenses	100%	50%	

SECTION C

DEFINITIONS OF GENERAL TERMS

When used and capitalized in this document, these terms have the following definitions. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of the Plan Document for that information.**

ALLOWED CHARGE means the maximum dollar amount eligible for payment for a procedure or service as determined by the Plan. This includes billed charges, contracted amounts or Usual, Customary and Responsible Fees, depending on the healthcare provider's relationship with the Plan and/or the healthcare services provided.

AMBULATORY SURGICAL CENTER means a facility with an organized staff of Physicians which:

1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
2. Provides treatment by and under the supervision of Physicians and nursing services when the patient is in the facility;
3. Does not provide Inpatient accommodations;
4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician.

ANNUAL OUT-OF-POCKET MAXIMUM means the total Coinsurance and Copay amounts for certain Covered Services that are a Plan Member's responsibility during a Coverage Year. The following amounts are *not* considered or taken into account: charges that are not Covered Services under the Plan (e.g., charges which exceed Usual, Customary and Reasonable Fee and costs paid by the Plan Member as a result of a failure to comply with Prior Authorization requirements), and charges in excess of Plan maximums. When the Annual Out-of-Pocket Maximum is met, the Plan will pay 100% of the Allowed Charge for certain Covered Services incurred during the remainder of the Coverage Year. The Annual Out-of-Pocket Maximum renews on the Plan anniversary of each consecutive Coverage Year.

BIRTHING CENTER means a facility operating as part of a Hospital, or as a free-standing facility solely engaged in providing an alternative to conventional obstetrics which:

1. Is licensed as such and is operating within the scope of its license; and
2. Is directed by a Physician specializing in obstetrics or gynecology; and
3. Has a Physician or certified nurse mid-wife, present at all births and during the immediate post-partum; and
4. Is equipped and has a trained staff, or has a written agreement with the Hospital to handle emergencies including the transfer of a patient or child; and
5. Maintains medical records on each patient and provides an ongoing quality assurance program.

CALENDAR YEAR means the period from January 1 through the following December 31.

CONFINEMENT means a continuous stay in the Hospital(s) or extended care facility(ies) or combination thereof, due to a Sickness or Injury diagnosed by a Physician, which lasts at least one day and one night.

COPAY means an amount payable by the Plan Member before benefits are payable by the Plan. In some instances, the Plan Member will be responsible at the time and place of service to pay any Copay directly to the healthcare provider. In other instances, the Plan Member will be billed by the healthcare provider. These arrangements are between the Plan Member and the healthcare provider.

COINSURANCE means the charge a Plan Member must pay for certain Covered Services after any applicable Copays have been paid and until the Annual Out-of-Pocket Maximum has been reached. Covered Services subject to Coinsurance and the amounts are listed in the Schedule of Coverage. Coinsurance is a percentage of the Allowed Charge. In some instances, the Plan Member will be responsible at the time and place of service to pay any Coinsurance directly to the healthcare provider. In other instances, the Plan Member will be billed by the healthcare provider. These arrangements are between the Plan Member and the healthcare provider.

COSMETIC PROCEDURE means a procedure performed solely for the improvement of a Plan Member's appearance rather than for the improvement or restoration of bodily

function. Breast reconstruction or a breast prosthesis following a mastectomy is **NOT** considered a Cosmetic Procedure.

COVERAGE YEAR means when services are covered under this Plan. This means that benefit maximums, Deductibles and Coinsurance limits start and stop during this time. The Plan's Coverage Year is January 1 – December 31.

COVERED SERVICE means healthcare services described in the Plan for which benefits will be provided, unless limited or excluded in the Plan. A Covered Service is Incurred on the date the healthcare service is received.

COVERED EXPENSES are charges for services that are covered under the Plan. Some charges, although eligible, may be subject to Deductible, Copay and Coinsurance provisions where applicable and, therefore, are the Plan Member's responsibility to pay. Charges for non-covered expenses are also the Plan Member's responsibility.

CREDITABLE COVERAGE means the period of time that an individual has been covered by any of the following medical programs:

1. This Plan;
2. Another group health plan;
3. Non-group or individual health insurance coverage issued by a state regulated insurer (including Blue Cross type plans) or an HMO;
4. Medicare (Part A or Part B);
5. Medicaid;
6. Title 10 U.S.C. Chapter 55;
7. American Indian Health Care Programs;
8. A state health benefits risk pool;
9. The Federal Employees Health Plan;
10. A "public health plan" including any plans established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;

11. The Peace Corp Health Program;
12. A State Children's Health Insurance Program (S-CHIP).

CUSTODIAL CARE means the type of care that is designed chiefly to help a person meet activities of daily living. It does not entail or need the continuing attention of trained medical personnel such as registered nurses and licensed practical nurses. Custodial Care includes services which make up personal care such as help in walking and getting in and out of bed; help in bathing, dressing, feeding, and using the toilet; preparation of special diets; and supervision of medication which usually can be self-administered. Care may still be custodial even though it involves the use of technical medical skills if those skills can be easily taught to a lay person.

DAY HOSPITALIZATION means the continuous treatment of a Mental/Nervous Disorders and/or Substance Abuse at a Hospital, intermediate care facility or other covered facility for not less than five hours and not more than eighteen hours in any 24-hour period. It does not include an Inpatient stay in the Hospital.

DENTIST means a duly licensed Dentist or Physician who is acting within the scope of his/her license.

DEPENDENT includes only an Employee's:

1. Spouse (Spouse means an individual as recognized as a spouse for purposes of federal tax laws, including the Code. A Spouse who is legally separated or divorced from the Employee is specifically excluded from the definition of Spouse); and
2. Unmarried or married children who are less than 26 years of age;
3. Unmarried children age 26 or older who are incapable of self-sustaining employment because of a developmental disability or physical disability and are chiefly dependent upon the Employee for support and maintenance. Proof of such incapacity must be furnished within 31 days of the children reaching the limiting age and annually thereafter.

"Developmental disability" means substantial handicap which results from mental retardation, cerebral palsy, or other neurological disorder.

"Physical disability" means a physical impairment that substantially limits one or more major life activities such as hearing; breathing; mobility (ability to move); learning; or receptive (understanding) and expressive

language. Physical disabilities include but are not limited to: blindness/visual impairment; cancer; diabetes; head injury; heart disease; and mobility impairments. An individual with a minor, non-chronic condition of short duration, such as a sprain, broken limb, or the flu, is not considered disabled.

4. Child for whom coverage is required by a Qualified Medical Child Support Order or by an administrative process established under state law.

The term children includes the following:

1. A biological child;
2. An adopted child, including a child placed for adoption. Placement for adoption occurs when an Employee, in anticipation of adopting a child, assumes and retains legal obligation for the total or partial support of that child. Adoptive placement ceases when or if legal obligation ceases;
3. A stepchild;
4. a child for whom the Employee and/or the Employee's Spouse has been named legal guardian, or
5. A child for whom the Employee is legally financially responsible.
6. A foster child.

At any time, the Plan may require proof that a spouse or child qualifies or continues to qualify as a Dependent as defined by the Plan.

Individuals specifically excluded from the definition of a Dependent are:

1. any person on active military duty;
2. the grandchild of an Employee and/ or the Employee's Spouse;
3. any person covered under this Plan as an Employee; and
4. any person covered as a Dependent by another Employee.

DIAGNOSTIC means a test or procedure performed because the Plan Member has specific symptoms or which is required to detect or monitor a certain condition or disease. Such test or procedure must be ordered by a Physician or Health Care Professional, and it must be related to the Plan Member's symptoms.

DURABLE MEDICAL EQUIPMENT means equipment which is prescribed by a Physician and is primarily and customarily used to serve a medical purpose, able to

withstand repeated use, and not generally useful to a person in the absence of an Injury or Sickness.

EBSO means EBSO, Inc.

EFFECTIVE DATE means the date on which a person's coverage under this Plan begins.

EMERGENCY/EMERGENCY CONDITION means a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;
2. Serious impairment to such person's bodily functions;
3. Serious dysfunction of any bodily organ or part of such person; or
4. Serious disfigurement of such person.

EMERGENCY SERVICES means with respect to an Emergency Condition:

1. a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and
2. such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as required to stabilize the patient.

EMPLOYEE means an Employee of the Employer who is regularly scheduled to actively perform the principle duties of his/her occupation a minimum of 30 hours per week, and who is enrolled and eligible for coverage under the Plan.

Part-time, seasonal, temporary and retired employees are not eligible for coverage under the Plan. Employee does not include the following:

1. a self-employed individual as described in Section 401 (c) of the Code, including, but not limited to, a sole proprietor if the Employer is a sole proprietorship, a person owning more than 2% of the Employer if it is a Subchapter S corporation, a partner of the Employer if it is a partnership, and a member of the Employer if it is a limited liability company and the members are treated as partners for income tax purposes;
2. an employee who is a spouse, child, grandchild, or parent of a person owning more than 2% of the Employer if it is a Subchapter S corporation;
3. any individual included within a unit of employees covered by a collective bargaining unit unless such agreement expressly provides for coverage of the Employee under the Plan;
4. any individual who is a nonresident alien and receives no earned income from the Employer from sources within the United States;
5. any individual who is a leased employee as defined in Section 414(n)(2) of the Code;
6. any individual who performs services for the Employer through, and is paid by, a third-party (including but not limited to an employee leasing or staffing agency) even if such individual is subsequently determined to be a common law employee of the Employer; or
7. any individual who performs services for the Employer pursuant to a contract or agreement (whether verbal or written) which provides that such individual is an independent contractor or consultant, even if such individual is subsequently determined to be a common law employee of the Employer.

EMPLOYER means City of San Luis.

ESSENTIAL HEALTH BENEFITS means:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;

7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

EXPERIMENTAL/INVESTIGATIONAL/INVESTIGATIVE means a drug, device, medical treatment or procedure that meets any of the following:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. The drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or
3. Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

For purposes of this definition, Reliable Evidence means published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

HEALTH CARE PROFESSIONAL means a licensed health care practitioner, other than a Physician (as defined by this Plan), who is legally licensed or certified and, within the scope of that license or certificate, is permitted to perform the services for which benefits are provided under this Plan. The term "Health Care Professional" includes, but is not limited to: a registered dietician, nurse midwife, audiologist, Physician's assistant, psychologist, nurse anesthetist, certified nurse practitioner, physical therapist, occupational therapist, speech therapist, speech pathologist, DME provider, License Practical Nurse (L.P.N.), Advanced Practice Registered Nurse, Radiation Therapist, Registered Nurse (R.N.), respiratory therapist, and an operating room technician (only when an assistant surgeon is not present). The Health Care Professional may be an independent Health Care Professional, however, his/her services must be recommended and approved by the Plan Member's attending Physician. The Health Care Professional may not be a member of the Plan Member's Immediate Family or a person who normally resides with the Plan Member.

HOME HEALTH CARE means care and treatment of a Plan Member provided by or coordinated through:

1. A Home Health Care Agency; or
2. A certified rehabilitation agency.

The care and treatment must be included in a Plan of Home Health Care approved in writing by the attending Physician. The Plan of Home Health Care must be revised every two months unless the attending Physician indicates in writing that a longer review period is sufficient. If the Plan Member was Hospital confined immediately prior to requiring home care, the Plan of Home Health Care must be approved by the Physician who was the primary provider of services during the confinement.

HOME HEALTH CARE AGENCY means a home health agency or a visiting nurses' association which meets all of the following requirements:

1. Is licensed by the state;
2. Qualifies as a Home Health Care Agency under Medicare;
3. Meets the standards of the applicable area-wide health care planning agency;
4. Provides skilled nursing services and other services on a visiting basis in the patient's home;
5. Is responsible for administering a Plan of Home Health Care; and

6. Supervises the delivery of a Plan of Home Health Care as prescribed and approved in writing by the patient's attending Physician.

HOME HEALTH CARE SERVICES means nursing services; dietary advice; social service guidance; physical, occupational, speech or respiratory therapy; laboratory services; drugs; dressings and medical supplies; and related services under the direction of a licensed Physician or surgeon provided in the place of and as an extension of care in a Hospital.

HOSPICE/HOSPICE CARE means an organization that provides medical, social and psychological services as palliative treatment for Plan Members with a terminal illness and life expectancy of less than six months.

HOSPITAL means a place that meets all of the following requirements:

1. It is accredited as a general Hospital by the Joint Commission on Accreditation of Hospitals;
2. It is open at all times;
3. It is operated chiefly for the treatment of sick or injured persons as Inpatients;
4. It has a staff of one or more Physicians available at all time;
5. It provides 24-hour nursing service by graduate registered nurses; and
6. It includes areas designed for diagnosis and major surgical procedures. Or, if it is chiefly a place for the treatment of mentally handicapped persons, it has an agreement, by contract or otherwise, with an accredited Hospital to perform Surgery which may be required.

The term "Hospital" does **NOT** include: a convalescent, nursing, rest, or Skilled Nursing Facility.

HOSPITAL MISCELLANEOUS EXPENSES means the actual charges made by a Hospital, other than room and board, on its own behalf for services and supplies rendered to the Plan Member, on an Inpatient or Outpatient basis, which are Medically Necessary for the treatment of such Plan Member. This includes Hospital admission kits, but all other personal or convenience items are excluded.

IMMEDIATE FAMILY means the Plan Member's spouse, children, brothers, sisters, grandparents, or the parents of the Plan Member or his/her spouse.

INCURRED means the day and time of day Covered Expenses are provided. It does not include a date on which a Plan Member contracts for future delivery of supplies or services.

INJURY means a condition caused by accidental means which results in damage to the Plan Member's body from an external force and independently of all other causes and which is **NOT** related to occupation or employment. Chewing accidents are **NOT** considered Injuries. Muscle strain due to athletic activity or other exertion is considered a Sickness under the Plan.

INPATIENT means that a Plan Member is confined as a registered bed patient in a Hospital, Skilled Nursing Facility, or other covered facility.

INSTITUTIONAL HEALTHCARE PROVIDER means healthcare providers including an Ambulatory Surgical Facility or Urgent Care Facility.

INTENSIVE CARE UNIT means a specialized section, ward or wing, within a Hospital which is operated exclusively for critically ill patients (other than Hospice patients) and provides special supplies, equipment and constant observation and care by registered professional nurses or other highly trained Hospital personnel, excluding any Hospital facility maintained for the purposes of providing normal post-operative recovery treatment or service.

MAINTENANCE CARE means continued care to maintain the optimum state of health after the Plan Member has reached a maximum level of recovery.

MASTER PLAN DOCUMENT means the Plan Document detailing the provisions of the Plan.

MEDICAID means the medical benefits provided by Title XIX of the Social Security Act, as amended.

MEDICALLY NECESSARY or **MEDICAL NECESSITY** means that a service, medicine or supply is necessary and appropriate for the diagnosis or active treatment of an Injury or Sickness based on generally accepted current medical practice.

To be Medically Necessary, Covered Expenses must:

1. Be rendered in connection with an Injury or Sickness;
2. Be consistent with the diagnosis and treatment of the Plan Member's condition; and
3. Be in accordance with the standards of good medical practice.

To be Medically Necessary, Covered Expenses must also be provided at the most appropriate level of care and in the most appropriate type of health care facility. Only the Plan Member's medical condition (not the financial status or family situation, the distance from a facility or any other non-medical factor) is considered in determining which level of care or type of health care facility is appropriate. Medically Necessary is the criterion by which the Plan determines the necessity of medical service and treatment under this Plan.

A service, medicine or supply will **NOT** be considered Medically Necessary if:

1. It is provided only as a convenience to the Plan Member or provider;
2. It is not appropriate treatment for the Plan Member's diagnosis or symptoms;
3. It exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
4. It is part of a plan of treatment that is considered to be Experimental/Investigational/Investigative in the diagnosis or treatment of an Injury or Sickness;
5. It involves the use of a drug or substance not formally approved by the United States Food & Drug Administration, even if approval is not required.

The fact that any particular Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

MEDICARE means the medical benefits provided by Title XVIII of the Social Security Act, as amended.

MENTAL/NERVOUS DISORDER(S) means a psychiatric or emotional disorder recognized as such by the American Psychiatric Association. "Mental/Nervous Disorders" include but is not limited to: psychotic, bi-polar, psychoneurotic disorders.

NURSE MIDWIFE means a person certified as a Nurse-Midwife to assist with childbirth under the direction and supervision of a licensed Physician.

OUT-OF-NETWORK means Health Care Professionals that are not in the Siarmed Network. There is no Out-of-Network coverage under this Plan, except for Health Care Professionals located in the United States, or Medically Necessary Emergency Services provided by non-Siarmed healthcare providers in Mexico.

OUTPATIENT means treatment rendered to a Plan Member at: a clinic; an Ambulatory Surgical Center; a Physician's office; or at a Hospital or other covered facility, other than as an overnight bed patient.

PAYMENT PERCENTAGE means the amount payable by the Plan for Covered Expenses after satisfaction of the Deductible amount or Copay amount, if applicable. The Payment Percentage is shown in the Schedule of Coverage.

PHYSICIAN means a legally licensed doctor of medicine and Surgery, doctor of optometry, psychiatrist, osteopathy, podiatric medicine, surgical chiropractic, or doctor of dental Surgery. A Physician shall not include the Plan Member or any member of his/her Immediate Family.

PLAN means the Plan of benefits offered by the Employer according to the provisions of the Master Plan Document.

PLAN YEAR means the twelve month period beginning from the effective date of this Plan. This Plan's Plan Year is July 1st through June 30th. The Plan Year may not be the same as the Coverage Year.

PLAN OF HOME HEALTH CARE for purposes of the Home Health Care benefit means a program for continued care and treatment of the Plan Member established and approved in writing by the Plan Member's attending Physician within 7 days following termination of a Hospital confinement as a resident Inpatient, and which is for the same or related condition for which the Plan Member was hospitalized. The attending

Physician must certify, and recertify every 90 days, that the proper treatment of the Injury or Sickness would require continued confinement as a resident Inpatient in a Hospital or in a Skilled Nursing Facility in the absence of the services and supplies provided as part of the Plan of Home Health Care.

PLAN MEMBER means an Employee or Dependent, as defined in the Master Plan Document, who is covered by the Plan.

PRESCRIPTION DRUG means medications and drugs that bear the legend “Federal law prohibits dispensing without a prescription.” This term also includes medicines and drugs that contain a legend drug that requires compounding by a pharmacist to the order of a Physician or other authorized Health Care Professional and are approved by the U.S. Food and Drug Administration (FDA). Insulin and diabetic supplies (e.g., syringes, lancets and testing strips) are generally covered as Prescription Drugs as well. Prescription Drugs include:

1. **Brand Name Drug** - a patent-protected Prescription Drug.
2. **Generic Drug** - Typically, a Prescription Drug on which patent has expired and manufactured by multiple pharmaceutical companies. FDA A-rated Generic Drugs (which are the only type of Generic Drugs covered under the Plan) contain the same active ingredient as the Brand Name Drug, are manufactured under the same FDA standards and are considered equivalent in all respects to the Brand Name Drug. Designation of Generic status is made by MediSpan, an independent, third party provider of prescription drug information based on the number of manufacturers of a given product and the price differential between the original product and subsequent manufacturers.
3. **Specialty Drug** – a Prescription Drug used to treat a specific, sometimes rare, medical condition. Specialty Drugs are typically expensive, often including bioengineered products, and require special handling, administration, monitoring, and patient education.

PRIMARY CARE PHYSICIAN means a Family Practitioner, General Practitioner, Pediatrician, OB/GYN, Internal Medicine Specialist, or Chiropractor.

PROTECTED HEALTH INFORMATION (PHI) means health information that is created or received by a Covered Entity, including the Plan, and relates to:

1. A person’s past, present or future physical or mental health;

2. Provision of health care to that person; or
3. Past, present or future payment for that person's health care.

To be considered Protected Health Information the information must be "individually identifiable health information" which means that in addition to the above requirements, the health information must identify the individual or a reasonable basis must exist to believe that an individual can be identified using the information. Protected Health Information covers information in any form (electronic, oral or written).

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) means a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Plan Member or eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address of the Plan Member and the name and mailing address of each such Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

In addition, a National Medical Support Notice (NMSN) shall be deemed a QMCSO if it:

1. Contains the information set forth below;
 - a. Name of an issuing state agency;
 - b. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Plan Member) or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate recipient(s);
 - c. Identity of an underlying child support order;
2. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated;

3. Informs the Plan Administrator that, if a group health plan has multiple options and the Plan Member is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and
4. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated Dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to Plan Members, except to the extent necessary to meet the requirements of a state law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

REHABILITATION FACILITY means a facility accredited by the Joint Commission on the Accreditation of Health Care Organizations or the Commission on the Accreditation of Rehabilitative Facilities as a Rehabilitation Facility for the primary purpose of physical rehabilitation. This facility may also be a ward, floor or other area contained within a Hospital whose primary purpose is physical rehabilitation.

RESCISSION or **RESCIND** means a cancellation of coverage or discontinuance of coverage under the Plan that has retroactive effect. Such action is prohibited under Health Care Reform unless attributable to (a) a failure to timely pay the cost of coverage, or (b) fraud or intentional misrepresentation of material fact, as those circumstances are described under Health Care Reform and regulatory guidance.

RESPITE CARE means care provided to a Plan Member receiving Covered Services for Hospice care, for the purpose of giving the Plan Member's uncompensated primary caregivers relief when necessary in order to maintain the Plan Member at home.

ROUTINE means any physical examination, including all related x-ray and laboratory tests, or any other medical procedure performed when the Plan Member is asymptomatic (i.e., which are **NOT** Medically Necessary for the diagnosis of a specific Injury or Sickness), including those performed on a Physician's recommendation due to the patient's family history.

SCHEDULE OF COVERAGE means the Schedule at the beginning of the Master Plan Document, or as later amended, which specifies the level of benefits provided by the Plan.

SECOND SURGICAL OPINION means a second opinion to evaluate the need for elective Surgery previously recommended by the patient's Physician provided that:

1. The charges that would be made for the recommended Surgery, if performed, must qualify as Covered Expenses;
2. The Physician furnishing the second opinion must not be financially associated with the Physician rendering the first opinion, and must be Board Certified in the appropriate medical specialty except: a Board Certified specialist is not required if the Physician has been recommended to the patient by a local medical society; and
3. The second opinion must be set forth in writing by the second Physician after the examination of the patient.

SIARMED NETWORK means the Siarmed network of Health Care Professional. For the Prescription Drug benefit, Siarmed Network shall mean the pharmacy network (as indicated on the ID Card). For medical and behavioral health services, Siarmed Network shall mean the Siarmed network in Mexico.

SICKNESS means a disorder of the body, a disease, condition, Mental/Nervous Disorder(s), Substance Abuse, pregnancy, or complication of pregnancy. All Sicknesses which are due to the same cause or to a related cause or causes will be deemed to be a Sickness.

SKILLED NURSING FACILITY means a place, or a distinct part of a place, which meets all of the following criteria:

1. It is licensed according to state or local laws;
2. Its chief purpose is to provide skilled nursing treatment to a Plan Member who is recovering from an Injury or Sickness;
3. It includes areas for medical treatment;
4. It provides 24-hour nursing service under the full-time supervision of a Physician or a graduate registered nurse (R.N.);

5. It maintains daily health records for each patient;
6. It has an agreement which provides for the services of a Physician;
7. It has a suitable method for providing drugs and medicines to patients;
8. It has an arrangement with one or more Hospitals for the transfer of patients;
9. It has an effective utilization review plan;
10. Its functions are developed with the advice and review of a skilled group which includes at least one Physician;
11. It is **NOT** solely a place for:
 - a. Rest, rehabilitation or Custodial Care;
 - b. The aged;
 - c. Treatment of Substance Abuse; or
 - d. Those who are mentally handicapped or who have Mental/Nervous Disorders.

SPECIALIST means a Physician other than a Primary Care Physician.

SUBSTANCE ABUSE means the overuse or addiction to alcohol and/or other drugs to the extent that is physically or mentally detrimental to the Plan Member, **EXCLUDING** nicotine and/or caffeine overuse or addiction.

SUMMARY HEALTH INFORMATION may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

SURGERY means:

1. The performance of generally accepted operative and cutting procedures. This includes related surgical supplies, specialized instrumentations, endoscopic examinations and other invasive procedures.
2. The correction of fractures and dislocations.
3. Injections of medication into joints and bursae for nerve blocks or as an alternative to Surgery, and injections of sclerosing agents and dyes used for radio-opacity.
4. Usual and related pre-operative and post-operative care.

URGENT CARE CENTER means a facility engaged primarily in providing minor emergency and episodic medical care. A board-certified Physician, a registered nurse, and a registered x-ray technician must be in attendance when the facility is open. The facility must include x-ray and laboratory equipment and life support equipment. For the purpose of this Plan, a facility meeting these requirements will be considered an Urgent Care Center, by whatever name it may be called.

USUAL, CUSTOMARY AND REASONABLE FEE means a charge for a given service by a provider to the majority of his clients, but such charge must be one which is within the range of fees charged by the majority of providers of similar training and experience, for that service within a specific, limited geographic or socioeconomic area as determined by the Plan. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill or expertise.

The term "area" as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross-section of a level of expenses.

The Usual, Customary and Reasonable Fee for surgical procedures mean Covered Expenses for the services of a Physician for performing an operation.

SECTION D

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

EMPLOYEE ELIGIBILITY DATE

For new Employees, coverage becomes available on the first of the month following the date of hire.

Employee absences due to health related factors will be credited toward the eligibility waiting periods. **NOTE:** The Plan will give credit for any waiting periods satisfied in whole or in part under the Employers' previous plan of benefits.

The above requirement regarding length of employment shall be waived in any instance where a Plan Member is merely changing from Dependent status to Employee status, or vice versa. In these instances, coverage shall continue without interruption.

If an Employee loses coverage in this Plan due to Injury, Sickness, layoff, or Employer approved leave of absence and returns to work for the Employer within 3 months of the loss of coverage, he/she will be eligible for coverage on the date of return to work and will **NOT** have to satisfy a new waiting period.

NOTE: If an Employee does not enroll for coverage under this Plan when he/she is initially eligible to enroll for coverage, he/she may enroll for coverage under this Plan at a later date subject to the Special Enrollment Period or the Open Enrollment Period, as explained elsewhere in the Plan Document.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

Coverage becomes effective on the date the eligibility requirement is satisfied, provided the Employee has enrolled for coverage within 30 days from the date he/she first satisfied the eligibility requirements.

DEPENDENT ELIGIBILITY DATE

An Employee becomes eligible for Dependent coverage on the later of:

1. The date the Employee becomes covered;
2. The date the Employee acquires an eligible Dependent; or

3. The date the Employee is required, by a Qualified Medical Child Support Order or by an administrative process established under state law, to provide Dependent coverage.

DEPENDENT EFFECTIVE DATE OF COVERAGE

A Dependent whose coverage is required under a medical support order will be eligible to participate in the Plan as of the date specified in the order, provided the medical support order satisfies the requirements of Arizona law. The Employer will review a medical support order and determine whether it is qualified under Arizona law. Upon request to the Employer, Members may obtain a copy of the procedures governing medical support order determinations, which is available at no charge.

All other Dependent coverage will become effective on the first of the month following one month from the Employee's date of hire. If Dependent status is acquired after the Employee's initial eligibility, the effective date of coverage shall be one month following the month in which the new Dependent becomes eligible for coverage under the Plan, provided the Employee completes a change form and submits it to the Employer within thirty (30) days after the attainment of Dependent status.

Individuals who become an eligible Dependent of an Employee after the Employee's Effective Date of coverage will be eligible for coverage as explained under the CHANGE IN STATUS provision.

NOTE: If an Employee does not enroll his/her eligible Dependents for coverage under this Plan when they are initially eligible to be enrolled for coverage, the Employee may enroll his/her eligible Dependents for coverage under this Plan at a later date subject to the Special Enrollment Period or the Open Enrollment Period, as explained elsewhere in the Plan Document.

CHANGE IN STATUS

If an Employee is covered for single coverage and wants to change to family coverage because of a change in marital status, he/she must request family coverage within 31 days of the date of marriage, in order for coverage to become effective on the date of the marriage.

Should an Employee's marital status change due to divorce or legal separation, notification of that change must be given to the Employer within 60 days of the date of that change.

Employees who have single coverage may request a change to family coverage to add an eligible Dependent child, by submitting a new enrollment form within 31 days of acquiring the child as an eligible Dependent, in which case the child's coverage would become effective on the date he/she became an eligible Dependent of the Employee.

Notwithstanding the foregoing, with respect to an Employee who acquires a new Dependent via birth, adoption, or placement for adoption, coverage for the new Dependent shall begin immediately upon birth, adoption, or placement for adoption and shall not be conditioned upon the enrollment of the new Dependent. However, if an additional premium is charged for the new Dependent and if the new Dependent fails to enroll within the thirty-one (31) day time period referenced above, the coverage shall cease upon expiration of such time period. Even if no additional premium is charged, the Employee should notify the Employer of the birth, adoption, or placement for adoption.

Any request for coverage after the 31 days will be subject to the Special Enrollment Period provision or the Open Enrollment Period.

SPECIAL ENROLLMENT PERIOD

If an Employee declines coverage for himself/herself or for his/her Dependents (including the Employee's spouse) because of other health coverage, the Employee will be able to enroll himself/herself and/or his/her Dependents in this Plan at a future date, provided that the Employee requests coverage within 31 days after other coverage ends. Coverage becomes effective on the first of the month following the date on which the request for enrollment was received by the Employer.

This special enrollment period **ONLY** applies to individuals whose prior Creditable Coverage:

1. Was under COBRA and they exhausted that COBRA coverage; or
2. Was not under COBRA and they lost that prior Creditable Coverage due to:
 - a. events that are similar to COBRA qualifying events (including, but not limited to loss of eligibility as a result of legal separation, divorce, death, termination or reduction in hours of employment or a child aging out under other parent's coverage);
 - b. the plan no longer offering any benefits to a class of similarly situated individuals (e.g. part-time employees);
 - c. the cessation of the employer contributions for that prior Creditable Coverage (actual termination of other coverage is not required);
 - d. moving out of an HMO's service area; or
 - e. reaching a lifetime limit for all benefits.

However, loss of eligibility does **NOT** include a loss due to failure of the individual to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

An Employee must make a request for Special Enrollment within 31 days of the loss of the previous Creditable Coverage and must supply the Plan with proof of loss of coverage under the other group health plan.

Additional Special Enrollment rights exist for Employees and their Dependents (who are eligible but not enrolled for coverage) upon either (1) termination of Medicaid or the State Children's Health Insurance Program (SCHIP) coverage resulting from loss of eligibility; or (2) becoming eligible for premium assistance in this Plan under a Medicaid or SCHIP program. In order to be entitled to this Special Enrollment right, the Employee must request coverage within 60 days of termination or the date the parent or child is determined to be eligible for assistance.

In addition, if an Employee, who declined coverage in this Plan for himself/herself or for his/her Dependents, acquires a new Dependent as a result of marriage, birth, adoption, or placement for adoption, the Employee will be allowed to enroll for coverage for himself/herself and/or his/her spouse and/or the new child, provided that the Employee requests coverage within 31 days after the marriage, birth, adoption or placement for adoption.

EXAMPLES:

1. In the case of marriage, an Employee who had previously declined coverage could become covered, with or without his/her spouse, under the Special Enrollment Period provision. Coverage becomes effective on the date of marriage.
2. In the case of birth or adoption, an Employee and/or his/her spouse, who had previously declined coverage in this Plan could become covered under the Special Enrollment Period provision. Coverage becomes effective on the child's date of birth, adoption or placement for adoption.

NOTE: During a Special Enrollment, the Employee may add a new Dependent under the Employee's current plan option or the Employee may switch to another option, **if applicable** (e.g., an Employee who is covered under this Plan may switch to an HMO plan offered by the Employer or change from one option under this Plan to another option under this Plan).

OPEN ENROLLMENT PERIOD

If an Employee declines coverage for himself/herself or for his/her Dependents (including the Employee's spouse) at the time such individuals are eligible for coverage, the Employee will be able to enroll himself/herself and/or his/her eligible Dependents during any Open Enrollment Period. Each year, during the month of **May**, the Employer will offer an Open Enrollment Period to eligible individuals (Employees and Dependents) who are not already covered under this Plan. Any individual enrolling for coverage under this Plan during an Open Enrollment Period (other than a new Employee who has not yet satisfied his/her eligibility-waiting period) will have coverage effective on the first of July.

NOTE: An Employee's eligible Dependent(s) may **NOT** be covered under this Plan unless the Employee is also covered. (This limitation does not apply to COBRA coverage.)

CHOOSING PLAN OPTIONS

Every year, during the month of May, the Employer will offer an annual enrollment period, during which an Employee who is presently enrolled under one Plan Option may elect to become enrolled in an alternate Plan Option. The effective date of the change in Plan Option will be July 1.

Employees who are presently enrolled under one Plan Option may also elect to become enrolled in an alternate Plan Option if they experience a family status change. A family status change will occur if the Employee gains or loses an eligible Dependent due to divorce, death, loss of eligibility, birth, marriage, adoption or a child reaching the maximum age limit.

Dependents covered by that Employee must be covered under the same Plan Option.

TERMINATION OF INDIVIDUAL COVERAGE

Coverage under this Plan shall terminate at midnight on the earliest of the following:

1. The date the Plan is terminated for all Plan Members;
2. The date a required contribution, if any, is due but the Plan Member fails to make the contribution;
3. With regard to a specific benefit, on the date the benefit is terminated or deleted from the Plan;
4. The date the Plan Member requests termination of any or all coverage under the Plan, subject to IRS Cafeteria rules. The request for termination must be in writing and all forms required by the Plan Administrator must be completed;

5. For Employees: If an Employee does not work the required number of hours to be considered an eligible Employee for any reason other than those specifically listed above, (i.e.; voluntary or involuntary termination of employment; or reduction in hours), coverage will terminate at the end of the month in which the Employee ceases full-time active work;
6. For Dependents:
 - a. Coverage will terminate on the same day as coverage terminates for the Employee under whom they are covered;
 - b. Coverage will terminate at the end of the month in which the individual no longer meets the Plan's Definition of an eligible Dependent;
 - c. For Dependents whose coverage became effective upon their birth, adoption, or placement for adoption under Change in Status, coverage will terminate on the date thirty-one (31) days from the effective date of coverage if an additional premium is charged for the new Dependent and the new Dependent fails to enroll with-in thirty-one (31) days following the birth, adoption, or placement for adoption.
 - d. Coverage will terminate on the date as specified in the Qualified Medical Child Support Order or by an administrative process established under state law if eligibility for Dependent coverage is solely based on this order.

NOTE: Coverage shall be canceled automatically, without notice, if a Plan Member:

1. Attempts, through deceit, to obtain benefits that otherwise would not be provided by this Plan; or
2. Attempts to obtain benefits for someone not entitled to benefits under this Plan.

Rescission. Coverage under this Plan may be Rescinded under certain circumstances. A determination by the Plan that a Rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Plan Member whose coverage is being Rescinded will be provided a 30 day notice period as described under Health Care Reform and regulatory guidance. Such notice shall be considered an Adverse Benefit Determination. At the conclusion of the 30 day notice

period, coverage shall be terminated retroactive to the date identified in the notification. Claims incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims.

This Plan shall at all times be in compliance with the applicable state family medical leave act and/or the Family and Medical Leave Act (FMLA) of 1993, or as later amended, provided the Employer is required to comply with such acts. The FMLA will run concurrently with any extension of coverage specified above.

SECTION E

CONTINUATION OF COVERAGE UPON INDIVIDUAL TERMINATION (COBRA)

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan ("Plan") offer Employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform Plan Members and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. The following paragraphs generally explain COBRA coverage, when it may become available and what a Qualified Beneficiary needs to do to protect his or her right to receive it.

We use the pronoun "you" in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a Qualified Beneficiary.

WHAT IS COBRA CONTINUATION COVERAGE? COBRA coverage is a temporary extension of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event". Specific Qualifying Events are listed below in the section entitled "What is a Qualifying Event".

The Plan has the following components, Medical and Prescription Drugs, and you may be enrolled in one or more of these components. COBRA (and the description of COBRA coverage contained in the plan document and summary plan description "SPD") applies only to the group health plan benefits offered under the Plan (the Medical and Prescription Drugs) and not to any other benefits offered by the Employer (such as life insurance, disability income, or accidental death or dismemberment benefits).

COBRA coverage is the same coverage that the Plan gives to other Plan Members under the Plan who are not receiving COBRA coverage. Each Qualified Beneficiary who elects COBRA will have the same rights under the Plan as other Plan Members covered under the component or components of the Plan elected by the Qualified Beneficiary, including Open Enrollment and Special Enrollment rights.

If an Employer offers more than one level of benefits and also offers an Open Enrollment Period (during which time, Plan Members are allowed to change to a different level of benefits or to add additional coverage, such as dental or vision), Qualified Beneficiaries must also be allowed to make these selections during an Open Enrollment Period.

In considering whether or not to take COBRA, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. You will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not obtain continuation coverage for the maximum time available to you. You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the Qualifying Event. You will also have the same special enrollment right at the end of continuation coverage if you obtained continuation coverage for the maximum time available to you.

WHO IS A QUALIFIED BENEFICIARY? In general, a Qualified Beneficiary is:

1. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the spouse of a covered Employee, or a Dependent child of a covered Employee.
2. A child born to, adopted by, or placed for adoption with a covered Employee during a period of COBRA coverage is considered to be a Qualified Beneficiary provided that, if the covered Employee is a Qualified Beneficiary, the covered Employee has elected COBRA coverage for himself/herself. The child's COBRA coverage begins when the child is enrolled in the Plan, including when enrolled through a Special Enrollment or an Open Enrollment.
3. A child who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO), received by the Employer during the covered Employee's period of employment with the Employer, is entitled to the same rights to elect COBRA as an eligible Dependent child of the covered Employee.

If however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer coverage constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes not only common-law Employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his/her performance of services for the Employer sponsoring the Plan (e.g., self-employed individuals, independent contractors, owners or corporate directors).

WHAT IS A QUALIFYING EVENT? If you are a covered **Employee** you will be entitled to elect COBRA if you lose your group health coverage under the Plan because of either of the following Qualifying Events:

1. your hours of employment are reduced; or
2. your employment ends for any reason other than your gross misconduct.

If you are a covered **spouse** of an Employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because of any of the following Qualifying Events:

1. your spouse dies;
2. your spouse's hours of employment are reduced;
3. your spouse's employment ends for any reason other than his/her gross misconduct;
4. your spouse becomes entitled to Medicare; or
5. you become divorced or legally separated from your spouse. Also, if your spouse (the Employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event for you even though your coverage was reduced or eliminated before the divorce or legal separation.

If you are a covered **Dependent child** of an Employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because of any of the following Qualifying Events:

1. the Employee dies;
2. the Employee's hours of employment are reduced;
3. the Employee's employment ends for any reason other than his/her gross misconduct;
4. the Employee becomes entitled to Medicare;
5. the parents of the Dependent child become divorced or legally separated; or
6. you stop being eligible for coverage under the Plan as a Dependent child.

If an Employee takes FMLA leave and does not return to work at the end of the leave,

the Employee (and the Employee's spouse and Dependent children, if any) will be entitled to elect COBRA if:

1. they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and
2. they will lose Plan coverage within 18 months because of the Employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave.)

If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the Employee and Dependents will be entitled to COBRA coverage even if they failed to pay the Employee portion of the contribution for coverage under the Plan during the FMLA leave.

WHEN IS COBRA COVERAGE AVAILABLE? When the Qualifying Event is the end of employment, reduction of hours of employment, or death of the Employee, the Plan will offer COBRA coverage to Qualified Beneficiaries. You need not notify the Employer of any of these three Qualifying Events. An Election Form will automatically be provided.

For the other Qualifying Events (divorce or legal separation of the Employee and spouse, or a Dependent child losing eligibility for coverage as a Dependent child), a COBRA Election Form will be sent to you only if you notify the Employer in writing within 60 days after the date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the Qualifying Event.

WHAT IS THE ELECTION PERIOD AND HOW LONG MUST IT LAST? An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Employer's Plan. A Plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of his/her right to elect COBRA continuation coverage.

HOW MAY COBRA COVERAGE BE ELECTED? To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA election notice and submit it to the COBRA Administrator.

Mail, hand-deliver or fax the completed Election Form to:

COBRA/Eligibility Department
EBSO, Inc.
2145 Ford Parkway, Suite 200
St. Paul, Minnesota 55116-1912
(651) 695-2500 or 1-800-486-7664
Fax number (651)695-1648

The Election Form must be completed in writing and mailed, hand-delivered, or faxed to the individual at the address/fax number specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; electronic communications, including e-mail messages; and faxed communications (unless they are on a proper Election Form).

If mailed, your Election Form must be postmarked (and if hand-delivered or faxed, your Election Form must be received by the individual at the address/fax number specified above) no later than 60 days after the date of the COBRA election notice provided to you at the time of your Qualifying Event. **IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.**

Each Qualified Beneficiary (including a child who is born to, adopted by or placed for adoption with a COBRA covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage. Covered Employees and spouses (if the spouse is a Qualified Beneficiary) may elect COBRA on behalf of all of the Qualified Beneficiaries, and parents may elect COBRA on behalf of their children.

Qualified Beneficiaries may be enrolled in one or more group health components of the Plan at the time of a Qualifying Event. If a Qualified Beneficiary is entitled to a COBRA election as the result of a Qualifying Event, he/she, may elect COBRA under any or all of the group health components of the Plan under which he/she was covered on the day before the Qualifying Event.

When you complete the Election Form you must notify the Employer if any Qualified Beneficiary has become enrolled under Medicare (Part A, Part B, or both) and, if so, the date of Medicare enrollment. If you become enrolled under Medicare (or first learn that you are enrolled under Medicare) after submitting the Election Form, immediately notify the Employer of the date of your Medicare enrollment at the address specified for delivery of the Election Form.

Qualified Beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are enrolled under Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing

COBRA, he/she becomes enrolled under Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied). See the section entitled “When may a Qualified Beneficiary’s COBRA continuation coverage be terminated?”.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the COBRA Administrator.

If you reject COBRA before the due date, you may change your mind as long as you furnish a completed Election Form before the due date.

WHAT ARE THE MAXIMUM COVERAGE PERIODS FOR COBRA CONTINUATION COVERAGE? The maximum coverage periods are based on the type of Qualifying Event and the status of the Qualified Beneficiary, as shown below:

1. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
2. In the case of a covered Employee’s enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
 - a. 36 months after the date the covered Employee becomes enrolled in the Medicare program. For example, if a covered Employee becomes enrolled under Medicare eight months before the date on which his employment terminates, COBRA coverage under the Plan for his spouse and Dependent children who lost coverage as a result of his termination can last up to 36 months after the date the Employee became enrolled under Medicare, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months). This COBRA coverage period is available only if the covered Employee becomes enrolled under Medicare within 18 months **BEFORE** the termination or reduction of hours; or
 - b. 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee’s termination of employment or reduction of hours of employment.

3. In the case of any other Qualifying Event than those described above, the maximum coverage period ends 36 months after the Qualifying Event.

In the case of a Qualified Beneficiary who is a child born to, adopted by or placed for adoption with a COBRA covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born, adopted or placed for adoption.

UNDER WHAT CIRCUMSTANCE CAN THE MAXIMUM COVERAGE PERIOD BE EXPANDED? If the Qualifying Event that resulted in your COBRA election was the covered Employee's termination of employment or reduction in hours, an extension of the maximum coverage period may be available if a Qualified Beneficiary is disabled or a second Qualifying Event occurs. You must notify the Employer of a disability or a second qualifying event in order to extend the period of COBRA coverage. **FAILURE TO PROVIDE NOTICE OF A DISABILITY OR SECOND QUALIFYING EVENT WILL ELIMINATE THE RIGHT TO EXTEND THE PERIOD OF COBRA COVERAGE.**

1. **Disability extension of COBRA coverage.** If a Qualified Beneficiary is determined by the Social Security Administration to be disabled and you notify the Employer in a timely fashion, all of the Qualified Beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for Qualified Beneficiaries who are receiving COBRA coverage because of a Qualifying Event that was the covered Employee's termination of employment or reduction in hours. The disability must have started at some time before the 61st day after the covered Employee's termination of employment or reduction of hours (this includes disabilities that began prior to the Employee's termination of employment or reduction of hours). The disability must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each Qualified Beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if you notify the Employer in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- a. the date of the Social Security Administration's disability determination;
- b. the date of the covered Employee's termination of employment or reduction of hours; or
- c. the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered

Employee's termination of employment or reduction of hours.

You must provide the Social Security Administration's determination notice within 18 months after the covered Employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

2. **Second Qualifying Event extension of COBRA coverage.** An extension of coverage will be available to spouses and Dependent children who are receiving COBRA coverage if a Second Qualifying Event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered Employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a Second Qualifying Event occurs is 36 months. Such Second Qualifying Events may include the death of a covered Employee, divorce or legal separation from the covered Employee, or a Dependent child's ceasing to be eligible for coverage as a Dependent under the Plan. These events can be a Second Qualifying Event only if they would have caused the Qualified Beneficiary to lose coverage under the Plan if the first Qualifying Event had not occurred. (This extension is not available under the Plan when a covered Employee becomes enrolled under Medicare.)

This extension due to a Second Qualifying Event is available only if you notify the Employer in writing of the Second Qualifying Event within 60 days after the later of:

- a. the date of the Second Qualifying Event; or
- b. the date on which the Qualified Beneficiary would lose coverage under the terms of the Plan as a result of the Second Qualifying Event (if it had occurred while the Qualified Beneficiary was still covered under the Plan).

WHAT IS THE COST OF COBRA CONTINUATION COVERAGE? The amount a Qualified Beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the group health Plan for coverage of a similarly situated Plan Member who is not receiving COBRA coverage (including both Employer and Employee contributions). The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

WHAT ARE THE COBRA CONTINUATION COVERAGE PAYMENT PROCEDURES? If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage no later than 45 days after the date of your election. (This is the date your Election Form is postmarked, if mailed, or the date your Election Form is received by the individual at the designated

address/fax number, if hand-delivered or faxed.) See the section above entitled “How may COBRA coverage be elected?”

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make the first payment. (For example, your employment terminates on September 30, and you lose coverage on September 30. You elect COBRA coverage on November 15. Your initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of your COBRA election.) You are responsible for making sure that the amount of your first premium payment is correct. You may contact the Employer using the contact information provided under the section entitled “How may COBRA coverage be elected?” to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, YOU WILL LOSE ALL COBRA RIGHTS UNDER THE PLAN.

After you make your first payment for COBRA coverage you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each Qualified Beneficiary will be disclosed in the election notice provided to you at the time of your Qualifying Event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. Following your election of COBRA coverage, you will receive a packet of 12 coupons to submit with your monthly COBRA premium. Periodic notices of payments due for these coverage periods will not be sent (that is, a monthly bill will not be sent to you for your COBRA coverage – it is your responsibility to pay your COBRA premiums on time).

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, YOU WILL LOSE ALL RIGHTS TO COBRA COVERAGE UNDER THE PLAN.

All COBRA premiums must be paid by check or money order. CASH WILL NOT BE ACCEPTED.

Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to:

COBRA/Eligibility Department
EBSO, Inc.
2145 Ford Parkway, Suite 200
St. Paul, Minnesota 55116-1912
(651) 695-2500 or 1-800-486-7664
Fax number (651)695-1648

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand-delivering a check if your check is returned due to insufficient funds or otherwise.

WHEN MAY A QUALIFIED BENEFICIARY'S COBRA CONTINUATION COVERAGE BE TERMINATED? COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can terminate before the end of the maximum coverage period for several reasons, which are described below.

COBRA coverage will automatically terminate before the end of the maximum coverage period if:

1. timely payment is not made to the Plan with respect to the Qualified Beneficiary. **NOTE:** Invalid payments (i.e., checks returned due to insufficient funds) will result in retroactive termination of coverage.
2. the Employer ceases to provide any group health plan (including successor plans) to any Employee.
3. a Qualified Beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the Qualified Beneficiary have been exhausted or satisfied).
4. a Qualified Beneficiary first becomes enrolled under Medicare benefits (Part A, Part B, or both) after electing COBRA.

5. during a disability extension period, the disabled Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled.

You must notify the Employer in writing within 30 days if, after electing COBRA, a Qualified Beneficiary becomes enrolled under Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the Qualified Beneficiary have been exhausted or satisfied). COBRA coverage will terminate (retroactively, if applicable) as of the date of Medicare enrollment or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any pre-existing condition exclusions for a pre-existing condition of the Qualified Beneficiary). The Employer will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare enrollment or other group health plan coverage.

If a disabled Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Employer of that fact within 30 days after the Social Security Administration's determination. If the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all Qualified Beneficiaries will terminate (retroactively, if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled. The Employer will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice that the disabled Qualified Beneficiary is no longer disabled. (For more information about the disability extension period, see the section above entitled "Under what circumstances can the maximum coverage period be expanded?")

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a Plan Member not receiving COBRA coverage (such as fraud).

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

DOES A QUALIFIED BENEFICIARY HAVE A DUTY TO KEEP THE PLAN INFORMED OF ADDRESS CHANGES? In order to protect your family's rights, you must keep the Employer and the Plan's Claims Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Employer and the Plan's Claims Administrator.

QUESTIONS? If you have questions about your COBRA continuation coverage, you should contact the Employer or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA).

Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

CONTACTS: You may obtain information about COBRA coverage on request from:

1. **The Employer (Plan Administrator):**

City of San Luis
1090 E. Union Street
San Luis, AZ 85349
928-341-8547

2. **COBRA Administrator:**

COBRA/Eligibility Department
EBSO, Inc.
2145 Ford Parkway, Suite 200
St. Paul, Minnesota 55116-1912
(651) 695-2500 or 1-800-486-7664
Fax number (651)695-1648

The contact information for the Plan may change from time to time. The information will be included in the Plan's most recent SPD (if you are not sure whether this is the Plan's most recent SPD, you may request the most recent one from the Employer).

YOU MUST GIVE NOTICE OF CERTAIN QUALIFYING EVENTS

If you or your Dependent(s) experience any of the following qualifying events, you or your Dependent(s) must notify the Plan Administrator/COBRA Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would end as a result of the qualifying event:

- your divorce or legal separation.
- your child no longer qualifies as a Dependent under the Plan.
- the occurrence of a secondary qualifying event as described in "Second Qualifying Event extension of COBRA coverage" (this notice must be received prior to the end of the initial 18-month or 29-month COBRA period). See "Disability extension of COBRA coverage" for additional notice requirements.

Notice must be made in writing and must include: the name of the Plan; name and address of the Employee covered under the Plan; name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g. divorce decree, birth certificate, disability determination, etc.).

Warning: If your notice is late, or if it is not completed and provided to the Employer as required, no Qualified Beneficiary will be offered the opportunity to elect COBRA coverage.

SECTION F

UNIFORMED SERVICES CONTINUATION AND REINSTATEMENT PROVISION

Continuation

A Plan Member who:

1. Is employed by the Employer;
 2. Is determined by the Employer to be eligible for benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA);
 3. Is absent from his/her position of employment with the Employer by reason of service in the uniformed services; and
 4. Would otherwise have his/her coverage under the Plan terminated,
- may elect to continue the coverage under the Plan that the Plan Member and his/her eligible covered Dependents had prior to such absence for a period not to exceed the lesser of:
1. The twenty four month period beginning on the date on which the Plan Member's absence begins; or
 2. The day after the date on which the Plan Member fails to apply for or return to a position of employment as specified by the Employer.

Reinstatement

Upon re-employment, coverage under the Plan will be reinstated for a person who was absent from his/her position of employment with the Employer by reason of service in the uniformed services, as well as for his/her eligible Dependents who were covered Plan Members under the Plan at the time the absence began provided that:

1. The person was a covered Plan Member under the Plan until the time his/her absence from employment with the Employer commenced by reason of service in the uniformed services;
2. The person makes application for re-employment within the time limit specified by the Employer; and

3. At the time the person makes application for re-employment, he/she is entitled to benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

In such instances, an exclusion of the Plan or waiting period will not be applied, if that exclusion of the Plan or waiting period would not have been applied had coverage not been terminated as a result of service in the uniformed services. This also applies to any eligible Dependent of the covered person who becomes covered by the Plan as a result of such reinstatement of coverage.

An exclusion or waiting period may be imposed for any Injury or Sickness determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of service in the uniformed services.

SECTION G

GENERAL LIMITATIONS AND EXCLUSIONS

The Plan will not provide benefits for the following, **UNLESS** specifically stated otherwise in this Plan:

1. **Abortions.** Elective abortion unless carrying the fetus to full term would seriously endanger the life of the mother. If complications arise after the performance of any abortion, charges incurred to treat those complications will be eligible, whether the abortion was eligible or not.
2. **Absence from Hospital.** Charges made by a Hospital for a period of time when a registered bed patient is absent from the Hospital (e.g., weekend passes).
3. **Acupuncture.** Acupuncture.
4. **After the Termination Date.** Charges after the Plan Member's termination from the Plan.
5. **Alternative Care.** Any service or supply not generally accepted in medical practice in the United States as necessary and appropriate for the diagnosis or treatment of the condition of the patient. For example, the following services shall be considered unaccepted charges for the purposes of this Plan, except as specified in the Covered Expenses:
 - a. Aroma therapy;
 - b. Bioenergetic therapy;
 - c. Biofeedback;
 - d. Carbon dioxide therapy;
 - e. Chelation therapy (unless due to heavy metal poisoning);
 - f. Homeopathy, herbal therapy, or naturopathy;
 - g. Megavitamin therapy;
 - h. Nutritional based therapy;
 - i. Primal therapy;

- j. Psychodrama;
 - k. Vision perception training.
5. **Anonymous support groups.**
6. **Athletic/Health Clubs.** Charges for enrollment in an athletic, health or similar club. Health club memberships and all services provided by a health club facility, air conditioners, room humidifiers, room dehumidifiers, air purifiers, food blenders, exercise equipment, orthopedic or therapeutic mattresses (except hospital-type beds or pressure-relieving mattresses as prescribed by a Physician), home or automobile modification, environmental change, pools, whirlpools, and similar items, even if recommended, ordered or prescribed by a Health Care Professional.
7. **Autopsies** and related charges.
8. **Blood and Blood Donor.** Processing, storage and administration charges related to self-donated blood for potential transfusion to the Plan Member unless incurred after the Plan Member is scheduled for surgery. Services of a blood donor.
9. **Breast Prostheses.** Charges for purchase of breast prostheses, except following a Medically Necessary mastectomy, in which case charges for breast prostheses (one unit per side per Calendar Year per Plan Member) will be covered.
10. **Cardiac Rehabilitation.** Phase III and Phase IV Outpatient cardiac rehabilitation programs. Phase III cardiac rehabilitation begins at the completion of Phase II and may continue for six months or more. The program consists of group education at a community exercise facility, Hospital or clinic, or may be a home exercise program. Phase IV cardiac rehabilitation is a non-medically supervised maintenance program.
11. **Claim Forms.** Expenses for completion of claim forms or for preparation of medical reports; for missed appointments or for computer, internet, and telephone consultations.
12. **Clergy.** Services of the clergy.
13. **Coma stimulation programs.**
14. **Cosmetic.** Cosmetic Procedures for beautifying purposes unless reconstructive Surgery is necessitated by an accidental Injury or Sickness, or Surgery is needed to restore normal bodily function due to a birth

defect. Breast reduction, unless Medically Necessary or following a Medically Necessary mastectomy. Reconstruction of the other breast to produce symmetrical appearance will be covered in the case of a unilateral mastectomy. Breast augmentation, except following a Medically Necessary mastectomy. Reconstruction of the other breast to produce symmetrical appearance will be covered in the case of a unilateral mastectomy.

15. **Court-Ordered Care.** Charges for health care ordered by the court (i.e. court ordered rehabilitative treatment or services), unless otherwise covered under the Plan.
16. **Criminal Activities.** Charges Incurred for treatment of an Injury or Sickness sustained while the Plan Member is participating in an illegal occupation; commission of, or an attempt to commit, a felony; or voluntary participation in a riot, insurrection or civil disobedience.
17. **Custodial or Maintenance Care.** Custodial Care or domiciliary care, Maintenance Care, rest cures, convalescent care, a place for the aged or a nursing home.
18. **Dental Care.** Dental care (**EXCEPT** for any dental procedures specifically covered by this Plan).
19. **Duplicate.** Duplicate services or supplies.
20. **Durable Medical Equipment.** Durable Medical Equipment, **EXCEPT** as specifically stated otherwise. Replacement or repair of Durable Medical Equipment, prosthetics or orthotics which are stolen; lost; or damaged or destroyed by Plan Member misuse, abuse, or carelessness. Charges for equipment, models, or devices having features over and above that which best meets the Medical Necessity of the Plan Member. Motor vehicles, lifts for wheelchairs, motorized wheelchairs, lifts for scooters or stair lifts. Standard over-the-counter batteries.
21. **Employer Facilities** - Services and supplies provided through a medical department, clinic or other facility provided by or maintained by the Plan Member's employer for the exclusive use of that employer's employees, or a medical clinic or similar facility for which services or supplies are or should be available without charge to the Plan Member.
22. **Environmental Change.** Inpatient confinement, when such confinement is primarily for environmental change or rest.
23. **Excess of Maximum Benefit.** Charges in excess of any maximum benefit stated in the Plan.

24. **Excess of Usual, Customary and Reasonable Fee.** For expenses made which are in excess of the Usual, Customary and Reasonable Fee.
25. **Exercise Programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
26. **Experimental.** Charges for services and supplies, which are Experimental/Investigational/Investigative. This exclusion does not apply to covered Routine Patient Costs incurred by a Plan Member who participates in an Approved Clinical Trial. Routine Patient Costs include all items and services consistent with the coverage provided in the plan that is typically covered for a Plan Member who is not enrolled in a clinical trial. Routine patient costs do not include 1) the investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis.
27. **Extended Institutional Healthcare Provider.** Extended Institutional Healthcare Provider stays for reasons other than Medical Necessity or the attending Physician has documented that care could be provided in a less acute care setting.
28. **Family Counseling.** Family counseling.
29. **Financial or legal** counseling services.
30. **Foot Care.** Charges related to the following conditions:
 - a. Weak, unstable or flat feet, bunions, unless an open cutting operation is performed;
 - b. Treatment of corns, calluses or toenails, unless at least part of the nail matrix is removed. This does **NOT** apply when treatment is Medically Necessary due to diabetes or peripheralvascular disease;
 - c. Orthopedic shoes, orthotics, arch supports or any such similar device which is not custom made.
31. **Genetic Counseling.** Genetic testing or counseling when it is solely intended to be informational to a Plan Member or when it is used solely to answer questions or clarify issues that would not prevent the deterioration

of a Plan Member's condition and directly impact the treatment being delivered to the Plan Member.

- 32. **Government.** Expenses Incurred by a Plan Member that may be covered or reimbursed by any public program, or by any national, state, provincial, county, or local government or any other political subdivision, instrumentality or agency thereof, except Medicare and Medicaid.
- 33. **Government Operated Facilities** - Services furnished to the Plan Member in any veteran's Hospital, military Hospital, institution or facility operated by the United States Government, by any state government, by any agency or instrumentality of such government, or any foreign government agency, for which the Plan Member has no legal obligation to pay for services rendered or expenses Incurred, **EXCEPT** services incurred and billed for non-service related conditions or for care or service furnished by a tax supported state Hospital for treatment of Mental/Nervous Disorders.
- 34. **Hair Loss.** Care and treatment for hair loss including hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.
- 35. **Hair Pieces.** Wigs and artificial hair pieces, unless related to a Sickness or Injury covered by this Plan.
- 36. **Halfway houses, wilderness programs,** group homes, or summer camps.
- 37. **Hearing Care.** Routine hearing care, except as stated otherwise under Preventive Care.
- 38. **Hemantinics.**
- 39. **Home Infusion Services.** Nursing services to administer home infusion therapy the Plan Member or another caregiver can be successfully trained to administer. Home infusion services that do not involve direct Plan Member contact, such as delivery charges and record-keeping.
- 40. **Hospice Care Services.**
- 41. **Hospital Employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and who is paid by the Hospital or facility for the service.
- 42. **Housekeeping or meal services** in the Plan Member's home.

- 43. **Hypnotism.** Expenses for hypnotism.
- 44. **Iontophoresis.**
- 45. **Immediate Family.** Services performed by a person who is a member of the Plan Member's Immediate Family or who resides in the Plan Member's home.
- 46. **Incurred by Another.** Charges actually Incurred by other persons.
- 47. **Infirmary.** Infirmary and other healthcare charges from a school or other educational facility.
- 48. **Infertility/Fertility/Adoption.** Services, drugs, or supplies for the purpose of, or related to the treatment of infertility, including drugs and procedures for the promotion of conception (i.e., assisted reproductive technology (ART) procedures, including sperm banking, artificial insemination, in vitro fertilization (IVGF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT), with or without cryopreservation or frozen embryo transfer, Including charges for donor ova or sperm), except the initial examination and tests required to diagnose infertility are Covered Expenses.

Infertility medications.

Charges related to or in connection with adoption.

Charges related to or in connection with surrogacy.

Lamaze or other childbirth classes.

Services of a doula.

Charges for donor ova or sperm unless specifically covered under the Plan.

- 49. **Inpatient Diagnostic Services, Therapy or Observation.** Charges for Hospital room and board and general nursing care when the Plan Member is admitted primarily for therapy services, diagnostic study or medical observation and if the necessary care can properly be provided on an Outpatient basis.
- 50. **Marriage/Sex Counseling.** Services or supplies for religious, marital, relationship or sex therapy, counseling or training services.

51. **Massage Therapy.** Charges for massage therapy, rolfing and related services.
52. **Naturopathy.**
53. **No Legal Obligation.** Expenses for which the Plan Member has no legal obligation to pay or for an expense which would not have been made if the person did not have coverage under this Plan.
54. **Not Medically Necessary.** Expenses, of any kind, that are not in connection with or are not Medically Necessary for the treatment of a Sickness or Injury (unless specifically stated otherwise in this Plan).
55. **Not Recommended.** For any service or supply which is not recommended or approved by a Physician.
56. **Nurse Midwife.** Delivery services of a certified Nurse Midwife when performed at an unlicensed, unaccredited facility.
57. **Nutritional Supplements.** Outpatient nutritional supplements Including home meals, food, food supplements, infant formulas etc., diets, vitamins, minerals, naturopathic or homeopathic services/substances, other nutritional supplies and over the counter electrolyte supplements, except as required for treatment of inborn errors of metabolism or enteral nutrition via tube.
58. **Over the Counter.** Ordinary over-the-counter items such as cotton balls/swabs, alcohol wipes, bandages and ace wraps. Over the counter home testing and monitoring supplies and devices unless used in the treatment of diabetes.
59. **Patient Education.** Services or supplies for education or training (this exclusion does **NOT** apply to diabetic self-management education programs); social skills training, developmental, educational, scholastic or vocational services or training, including but not limited to: computers and computer software programs, treatment for scholastic improvement, vocational training, visual coordination, motor coordination, and special education for the learning disabled. (**NOTE:** this does **NOT** apply to medically necessary therapy).
60. **Penile prosthesis/implants.**
61. **Personal Convenience Items.** Telephone, television, radio, guest trays, personal hygiene or convenience items (other than Hospital admission kits), take-home drugs following discharge from a Hospital, air conditioners, air purifiers, physical exercise equipment, and similar items.

62. **Personal Growth.** Expenses for personal growth/development, hypnotherapy, holistic medicine or other programs with an objective to provide complete personal fulfillment.
63. **Prescription Drugs/Medications.** Outpatient non-legend (over-the-counter) drugs or any Prescription Drug with an over-the-counter equivalent -- regardless of whether there is a prescription, except insulin and nicotine replacement products and those products required by applicable law or regulations.

Phone consultations for the purpose of reviewing records or renewing prescriptions.

The cost of administering Prescription Drugs that are designed for self-administration.

Cosmetic medications.

Anti-wrinkle agents for cosmetic use (e.g., Avage, Renova).

Hair growth stimulants for cosmetic use (e.g., Rogaine).

Tretinoin (e.g., Retin-A) for Plan Members over age 25 for cosmetic purposes.

Hair removal products (e.g., Vaniqa).

Drug efficacy study indicator (DESI) drugs (Prescription Drugs determined by the FDA as lacking substantial evidence of effectiveness).

Emergency contraceptives (e.g., Next Choice, Plan B).

Erectile dysfunction medications (e.g., Viagra, Muse, Yohimbine) except when prescribed for pulmonary artery hypertension, benign prostatic hypertrophy, post-prostatectomy, or Raynaud's disease.

Fluoride supplements; except those required by Healthcare Reform Legislation.

Mineral and nutrient supplements, except when required by law or regulation, including, fluoride, folic acid and iron).

Pigmenting/depigmenting agents, except psoralen products.

Prescription Drugs labeled “investigational” or “experimental”, except that routine patient costs furnished in connection with an Approved Clinical Trial are covered. Routine patient costs include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis.

Replacement of Prescription Drugs that are lost, stolen, damaged or misplaced.

Vitamins, singly or in combination, except prescribed prenatal vitamins, and those required by applicable law or regulation.

Duplicate Prescription Drugs.

- 64. **Prior to Effective Date.** Charges Incurred prior to a Plan Member’s Effective Date under the Plan.
- 65. **Private Duty Nursing** services.
- 66. **Private Room.** Charges for a private room, unless Medically Necessary.
- 67. **Professional Certifications.** Charges for professional certification, licensure or the like.
- 68. **Prohibited by Law.** Services that are prohibited by law or regulation.
- 69. **Recreational Therapy.**
- 70. **Respite Care.** Respite Care.
- 71. **Reversal of Sterilization.** Charges for reversal of a sterilization procedure.
- 72. **Routine.** Any Routine physical examinations or tests not connected with an actual Sickness or Injury except as provided in the Preventive Services subsection of the Plan.
- 73. **Safety/Sport Related Items** – Devices used specifically as safety items or to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs such as athletic training,

bodybuilding, exercise, fitness, flexibility, diversion therapy, work hardening, or general motivation.

- 74. **Self-care and self-help training.**
- 75. **Sensory integration deficit therapy.**
- 76. **Smoking Cessation.** Except as stated otherwise in the Plan, charges for services, supplies and for smoking cessation programs, or charges related to the treatment of nicotine addiction, including smoking deterrent patches.
- 77. **Social Worker.** Services of a social worker.
- 78. **Surrogacy** related to in connection with adoption.
- 79. **Taxes.** Charges for taxes or surcharges, other than those that a medical facility is legally required to make.
- 80. **Therapeutic Devices.** Therapeutic devices or appliances [including needles and syringes (except as diabetic supplies), support garments and other non-medicinal substances, regardless of intended use].
- 81. **Third Party Exams.** Physical examinations for research or obtaining licensure or insurance.
- 82. **TMJ.**
- 83. **Tomosynthesis.**
- 84. **Transplants.** Charges for services, chemotherapy, supplies, drugs and aftercare for or related to transplants not specifically listed in the Plan.

High dose chemotherapy with autologous bone marrow transplantation to treat breast cancer.

Charges associated with the purchase of any organ.

Services or supplies furnished in connection with the transportation of a living donor.

Re-transplants within a 365 day period following the original transplant procedure.

Fetal umbilical cord blood stem cell transplantation.

85. **Transsexual Surgery.** Charges Incurred for transsexual Surgery and for any treatment leading to or in connection with sexual transformation.
86. **Transportation.** Expenses related to transportation to or between healthcare facilities, except as specifically provided under the Ambulance benefit.
- Non-Emergency Ambulance services.
87. **Travel.** Travel or accommodations for health, whether or not recommended by a Physician.
88. **Unlicensed Providers.** Any services rendered by unlicensed/uncertified providers, if a license or certificate is required by law where the services are rendered, or services that are outside the scope of the license of a provider. This **exclusion does not apply** to interpreter services if necessary to provide Covered Services to a Plan Member.
89. **Vision.** Expenses for eyeglasses, contact lenses, or for the fitting or examination of such, unless required due to intraocular Surgery or Injury to the eye or as stated otherwise in the Plan. Charges for confinement, treatment, service or materials for Kerato-Refractive Eye Surgery (Surgery to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea, including but not limited to radial keratotomy and keratomileusis Surgery) or LASIK Surgery.
- Vision therapy or eye exercises.
- Sunglasses (Including any colored or tinted lenses) or safety glasses.
- Repair of lenses or frames.
- Refractive cataract lenses after cataract surgery.
90. **War/Military Service.** Services or supplies Incurred due to an Injury or Sickness caused by war or an act of war (whether declared or undeclared), nuclear explosion or nuclear accident or major nuclear disaster, or service in the armed forces of any country. An act of terrorism will not be considered an act of war, declared or undeclared.
91. **Weekend Admission.** Initial Friday, Saturday and Sunday room and board charges Incurred for Hospital confinement which begins on Friday, Saturday or Sunday. This exclusion does not apply to Emergency admissions, pregnancy or scheduled Surgery within the 24-hour period immediately following Hospital admission.

92. **Weight Loss.** Routine treatment of obesity, or weight control counseling (including fees, vitamins, nutrients, supplements, or exercise therapy) and any related diagnostic testing unless necessitated as the result of a specifically identifiable condition of disease etiology, except medical nutrition therapy is a Covered Service. Preventive screening and counseling are Covered Services as listed under Preventive Care benefits.

Gastric bypass surgery for weight loss (bariatric surgery) regardless of the reason.

93. **Worker's Compensation.** Expenses due to a work-related Injury or Sickness sustained while doing anything pertaining to any occupation or employment for remuneration or profit for which all or part of the expense is payable by workers' compensation or similar law.

Notwithstanding the above exclusions, the Plan will not deny benefits for Covered Expenses for treatment of an Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

SECTION H PRE-CERTIFICATION

PRE-CERTIFICATION IS REQUIRED FOR THE FOLLOWING SERVICES:

- All non-Emergency Hospitalizations (including skilled nursing facility, inpatient rehabilitation and residential treatment facilities)
- Outpatient surgery
- Special Services, such as podiatry
- CT Scans, Pet Scans and MRIs
- Home Health Care
- Out-of-Network Durable Medical Equipment > \$750 or when rental exceeds 4 months
- Inpatient Rehabilitation/Habilitation services

FOR PRE-CERTIFICATION CALL EBSO-REVIEW, AT 1-800-426-9317. Non-compliance reduces benefits. If a Plan Member does not comply with Pre-certification when required, Covered Expenses will be reduced by a penalty of
Siarmed: \$250 per service or
Out-of-Network (US providers): 40% of the total cost of the service.

Please be prepared to supply the following basic information:

1. Patient's name and date of birth
2. Employee's name, address and phone number
3. Physician's name and phone number
4. Name of the Hospital
5. Reason for the hospitalization
6. Date the hospitalization started
7. Employer's I.D. Number.

SECTION I

COMPREHENSIVE MAJOR MEDICAL BENEFITS

UNLESS SPECIFICALLY STATED OTHERWISE THE FOLLOWING SERVICES AND SUPPLIES ARE SUBJECT TO THE DEDUCTIBLE, PAYMENT PERCENTAGES AND MAXIMUM PAYMENT AMOUNTS SHOWN IN THE SCHEDULE OF COVERAGE, TO THE USUAL, CUSTOMARY AND REASONABLE FEE LIMITATION, TO THE GENERAL EXCLUSIONS AND LIMITATIONS, AND TO ALL OTHER PROVISIONS OF THE PLAN. ALL EXPENSES MUST BE INCURRED AS THE RESULT OF AN INJURY OR SICKNESS AND BE RECOMMENDED BY A PHYSICIAN AS MEDICALLY NECESSARY, UNLESS SPECIFICALLY STATED OTHERWISE.

NOTE: Claims may not be received or processed in the same order that a Plan Member has received service. The Deductible and Payment Percentage will be applied to covered services in the sequence that claims are submitted and processed for payment.

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your network provider. Their website and telephone number are listed on the back of your ID card.

To the extent an item or service is a Covered Expense under the Plan, and consistent with the Plan's reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan is prohibited from discriminating against a provider based on the provider's license or certification, as long as the provider is acting within the scope of the provider's license or certification under applicable state law.

COVERED EXPENSES

1. **Allergy Testing, Injections and Serum.** Allergy testing, injections and serum when rendered by a Physician or Health Care Professional.

2. **Ambulance Services. This benefit applies to US Providers ONLY.** Emergency transportation by local professional ground or air ambulance service:

- a. From the Plan Member's home, scene of accident or medical Emergency to a Hospital; or
- b. Between Hospitals and/or Skilled Nursing Facility.

Transportation is limited to the nearest facility equipped to treat the condition.

3. **Anesthetics.** Anesthetics and their administration when rendered in connection with an eligible surgical procedure and when administered by an anesthesiologist, Physician or by a registered nurse (under supervision of a Physician).
4. **Autism.** Charges for the treatment of Autism.
5. **Birthing Centers. This benefit applies to US Providers ONLY.** Charges made by a Birthing Center are covered on the same basis as if the charges had been made by a general Hospital.
6. **Blood Services.** Blood services, including whole blood, blood components, and blood processing administration. The Plan will not pay for the whole blood or blood components when donated or otherwise replaced by or on behalf of the patient.
7. **Circumcisions.** Circumcisions (including Routine circumcisions) and the related charges for all male Plan Members.
8. **Clinical Trial Routine Patient Costs** incurred by a Qualified Individual who participates in an Approved Clinical Trial. If a Plan Member is covered under a Preferred Plan, as shown on the Schedule of Coverage, a Qualified Individual who wishes to participate in an Approved Clinical Trial must use a Preferred Provider if a Preferred Provider is participating in the trial and the Preferred Provider accepts the Qualified Individual as a participant in the trial. However, if a Plan Member is covered under a Preferred Plan, and the Approved Clinical Trial is either conducted outside the state in which the Qualified Individual resides by an Out-of-Network US provider or there is no Preferred Provider conducting the Approved Clinical Trial and accepting the Qualified Individual in the individual's state of residence, then Routine Patient Costs will be covered as if provided by a Preferred Provider.

For the purpose of this Benefit, the following definitions apply:

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV Clinical Trial that is (1) conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and (2) is one of the following:

- a. Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - i. The National Institutes of Health.
 - ii. The Centers for Disease Control and Prevention.
 - iii. The Agency for Health Care Research and Quality.
 - iv. The Centers for Medicare & Medicaid Services.
 - v. A bona fide Clinical Trial Cooperative group or center of any of the entities described in clauses i) through iv) above or the Department of Defense or the Department of Veterans Affairs.
 - vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - vii. Any of the following in clauses a. – c. below if the following conditions are met: The study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - a) The Department of Veterans Affairs
 - b) The Department of Defense
 - c) The Department of Energy; or
- b. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- c. The study or investigation is a drug trial that is exempt from the investigational new drug application requirements.

Life-threatening Condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Qualified Individual means a Plan Member who meets the following conditions:

- a. The individual is eligible to participate in an approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening diseases or conditions.
- b. Either:
 - i. The referring health care provider has concluded that the Plan Member's participation in the Clinical Trial would be appropriate based upon the Plan Member meeting the conditions described in paragraph a. above; or
 - ii. The Plan Member provides medical and scientific information establishing that participation in such trial would be appropriate based upon the Plan Members meeting the conditions described in paragraph a. above.

Routine Patient Costs means all items and services that are typically covered by the Plan for a Qualified Individual who is not enrolled in a Clinical Trial. Routine Patient Costs do not include:

- a. The investigational item, device, or service, itself;
 - b. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
 - c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
9. **Corneal grafts/Sclera shells.** Charges in relation to corneal grafts, and, for aphakic patients, soft lenses or sclera shells intended for use as corneal bandages.
10. **Dental Services.** This is not a comprehensive dental plan. Covered Services under the Plan include only the following dental services or oral maxillofacial services that relate to a Plan Member's medical condition:
- a. Treatment of acute, accidental, traumatic Injuries to sound, natural teeth (including replacement of avulsed teeth due to traumatic complications) or jaws. Coverage is for an Injury that results from external trauma to face and mouth only, not for cracked or broken teeth which result from biting or chewing.

The following are Covered Services under the Plan only if they are a direct result of the Injury:

- i. dental implants;
- ii. orthodontia;

- iii. fixed or removable dental prosthetic devices, including crowns, bridges, and dentures;
- iv. corrections of malocclusions.

b. Coverage for oral surgery is limited and includes the following Covered Services under the Plan:

- i. Oral surgical treatment of, and orthodontic services related to the management of cleft lip or cleft palate for Dependents up to age 18.

The following are Covered Services under the Plan only if they are a direct result of the cleft lip or cleft palate:

- dental implants;
- orthodontia (If a Dependent child covered under the Plan is also covered under a dental plan which includes orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services.);
- fixed or removable dental prosthetic devices, including crowns, bridges, and dentures;
- or corrections of malocclusions.

- ii. Oral surgery for tumors or cysts of the jawbone or mouth.

The following are Covered Services under the Plan only if they are a direct result of the illness:

- dental implants;
- orthodontia;
- fixed or removable dental prosthetic devices, including crowns, bridges, and dentures;
- corrections of malocclusions.

- iii. Oral surgery for the removal of bony impacted or partially bony impacted teeth.

- iv. Osseous surgery.

11. **Diabetic Education.** Diabetic education and training for self-management programs for Plan Members with diabetes.

12. **Dialysis services.** Charges for dialysis, wherever performed. Charges for supplies and rental of dialysis equipment for home dialysis. This does **NOT** include charges for set-up or for furniture.

13. **Foot Conditions.** Charges for treatment for the following foot conditions:

- a. Metatarsalgia or bunions when an open cutting operation is performed;
- b. Corns and calluses or toenails when at least part of the nail root is removed or due to peripheralvascular disease.

14. **Home Health Care Agency. This benefit applies to US Providers ONLY.** Charges made by a Home Health Care Agency for services rendered to a Plan Member due to an Injury or Sickness. Eligible Home Health Care Services begin on the day of initial treatment by a Home Health Care Agency. No amount will be payable for Home Health Care charges unless the following conditions are met:

- a. Continued confinement in a Hospital or Skilled Nursing Facility would have been required if Home Health Care had not been available;
- b. The care at home is Medically Necessary and is not primarily for Custodial Care;
- c. The treatment at home is for the same illness or related condition that made the Hospital and Skilled Nursing Facility confinement necessary;
- d. A Physician must have given a written order for Home Health Care Services.

Covered Services shall consist of:

- a. Part-time or intermittent nursing care by or under the supervision of a Registered Professional Nurse (RN);
- b. Part-time or intermittent services of a home health aide;
- c. Physical, occupational or speech therapy;
- d. Dietary guidance; and
- e. Medical supplies, medical appliances, medical equipment, drugs and/or medications prescribed by the attending Physician. These services may be provided on an Outpatient basis by a Home Health Care Agency, by a Hospital or other facility under an arrangement with a Home Health Care Agency.

Services not covered under the Home Health Care benefit include, but are not limited to: dietitian services, homemaker services, maintenance therapy, dialysis treatment, purchase or rental of dialysis equipment, food or home delivered meals.

Benefits are limited to the maximums set forth in the Schedule of Coverage. A Home Health Care visit shall consist of four hours of service provided through the Home Health Care Agency.

15. **Inpatient Hospital Services.** Hospital charges for Hospital Miscellaneous Expenses, wards, semi-private rooms, cardiac care (including Phase I cardiac rehabilitation while the Plan Member is an Inpatient), Intensive Care Units, nursery rooms for newborn sick and well babies, and private rooms, (provided such confinement is Medically Necessary for the Plan Member's condition). If private room confinement is not Medically Necessary for the Plan Member's condition, the Plan will consider as a Covered Expense an amount equal to the Hospital's semi-private room rate. Charges for private rooms are covered only when Medically Necessary.

For any covered maternity, the Plan will not limit benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require notification of a length of stay not in excess of the above periods.

NOTE: When the delivery is outside of the Hospital, the minimum period of Hospital stay begins when the mother or newborn is admitted. The attending Physician will determine whether an admission is in connection with childbirth, and thereby eligible for the minimum length of stay.

16. **Maternity Care.** Maternity Care including Outpatient facility services and Physician medical and surgical services (including office visits) for normal pregnancy, miscarriage, and complications of pregnancy.

This benefit is available to all Plan Members. Additional benefits may be covered under Preventive Care benefits and are available to all Plan Members.

Note: Charges Incurred for maternity Inpatient admissions are payable under the Inpatient Hospital services benefit.

This benefit will also include the services of a certified Nurse-Midwife for care performed under the direction and supervision of a licensed Physician. The supervising Physician shall be identified and the cost of supervision is a

reimbursable expense. Total fees cannot exceed the fee the Physician would have charged had he provided the entire service.

Services provided in connection with the birth of a child who is legally adopted by a Plan Member if all of the following are true:

- a. the Dependent was adopted within one year of his/her birth;
- b. the Plan Member is legally obligated to pay the costs of the adopted Dependent's birth;
- c. the Plan Member has satisfied all applicable limitations set forth in this Plan; and
- d. the Plan Member has notified the Employer of the Plan Member's acceptability to adopt children under Arizona law within sixty (60) days of the later of:
 - i) receipt of approval from the State, or
 - ii) becoming covered under the Plan.

17. Medical Supplies/Durable Medical Equipment/Prosthetics/Orthotics.

Covered Services under the Plan Include the following types of Medically Necessary Durable Medical Equipment, Prosthetics, Orthotics and Disposable Supplies, but only if prescribed by a Healthcare Provider for use outside of a Hospital or Skilled Nursing Facility. Covered Services Include:

- a. Nebulizer;
- b. Breast Pump;
- c. Hearing aid (limit of 1 per ear per Plan Member per Calendar Year, only covered in the US at 20% co-insurance); and

Repair of Durable Medical Equipment. Separate charges for the repair of Durable Medical Equipment are Covered Expenses if such equipment is being purchased or is already owned by the Plan Member and repair is necessary to make the equipment serviceable. When repair costs exceed the estimated cost for purchasing or renting the same item for the remaining period of medical need, such excess repair costs are not a Covered Expense. Rental of Durable Medical Equipment while a Plan Member's own Durable Medical Equipment is being repaired is a Covered Expense.

Replacement of Durable Medical Equipment. Durable Medical Equipment that a Plan Member owns, is purchasing, or renting may be replaced in the event of loss, irreparable damage (due to accident or natural disaster) or irreparable wear (i.e., deterioration due to usage over time, not due to a specific event) or when required because of a change in the Plan Member's medical condition or to accommodate bodily growth.

Replacement of Durable Medical Equipment due to irreparable wear is not a Covered Expense during the reasonable useful lifetime of the Durable Medical Equipment; however repair costs up to the estimated cost of replacement of such equipment may be a Covered Expense. This plan reserves the right to re-evaluate Medical Necessity of Durable Medical Equipment associated with a request for replacement of such equipment.

18. **Mental/Nervous Disorders and/or Substance Abuse.** Charges for the treatment of Mental/Nervous Disorders and/or Substance Abuse when recommended by or under the clinical supervision of a licensed Physician or a licensed psychologist. Such treatment must be recognized as appropriate in accordance with broadly accepted standards of medical practice. Charges are payable as shown in the Schedule of Coverage.

Eligible Inpatient Services: Room & board and miscellaneous charges. Medical services including individual and group psychotherapy, psychological testing, family counseling, and convulsive therapy.

Day Hospitalization will be payable under this Plan.

Eligible Outpatient Services: Medical services including individual and group psychotherapy, psychological testing, family counseling, and charges by an approved treatment facility.

19. **Outpatient Facility Services.** Services and supplies received in connection with treatment rendered in the Outpatient department of a Hospital, **Urgent Care Center**, emergency room, emergency care clinic or **Ambulatory Surgical Center**.
20. **Outpatient Prescription Drugs and Medicines.** Outpatient Prescription Drugs and medicines lawfully obtainable upon the written prescription of a Physician.
21. **Oxygen.** Charges for oxygen and other gases and their administration.
22. **Physicians' Services.** The following services and supplies when performed by a Physician or any other properly licensed/certified Health Care Professional, while acting within the scope of his/her license/certificate, are considered Covered Expenses:
- a. Covered Expenses for **visits** made by a Physician to a Plan Member while confined as an **Inpatient** in a covered medical facility. Consultations when requested by the attending Physician, limited to one consultation per day per specialist. This includes Routine pediatric examinations of a newborn sick or well baby.

- b. Covered Expenses made by a Physician, for Hospital Outpatient services, **office visits or home visits** for diagnosis and treatment of a specific Injury or Sickness, including voluntary **second or third surgical opinions; immunizations and injections of medication** (including the medication) related to a covered Injury or Sickness.
- c. **Surgical Services** - Eligible charges are covered for Surgery when performed in a Hospital, Outpatient department of a Hospital, Ambulatory Surgical Center, Physician's office or clinic.

For documented multiple surgical procedures the Plan shall cover the greater surgical procedure at 100% of the Usual, Customary and Reasonable Fee and 50% of the Usual, Customary and Reasonable Fee for each lesser procedure during the same operative session.

NOTE: Charges for the treatment of separate and distinct fractures and surgeries that require the skills of two or more surgeons who have different specialties and when each performs a separate operation are covered at 100% of the Usual, Customary and Reasonable Fee.

Covered Expenses include Hospital pre-operative and post-operative care. Covered Expenses for surgical services include, for example, the following:

- i. **Cosmetic Procedures** required as a result of an accidental Injury.
- ii. **Breast reconstruction** in connection with a mastectomy, including:
 - a) Reconstruction of the breast on which the mastectomy was performed;
 - b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - c) Prostheses and physical complications, all stages of mastectomy, including lymphedemas.
- iii. **Functional repair** or restoration of any body part when Medically Necessary to achieve normal body function. Charges for reconstructive or cosmetic surgery to restore

bodily function or correct deformity related to a congenital anomaly in a child up to age eighteen (18);

- iv. Charges for an **assistant surgeon**.
- v. **Voluntary sterilizations**, including all related charges, for all Employees and Dependent spouses.

The word “visit” means a personal interview between the Plan Member and a Physician and does not include telephone calls or interviews in which the Physician does not see the Plan Member for treatment.

23. **Preventive Care Services.** Covered Expenses shall include Routine physical exams (including the related office visit) and the following services:

- a. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;
- b. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved;
- c. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- d. With respect to women, to the extent not described in 1 above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA.

Any changes to the recommendations or guidelines referred to above will not be deemed Preventive Services until the first day of the Plan Year beginning on or after the date that is one year after the new recommendation or guideline went into effect.

Covered Services are provided for Preventive Care, Including:

- a. Well-baby/child exams and routine periodic preventive exams, Including routine gynecological exams
- b. This includes required school and school athletic physicals and camp physicals
- c. Preventive care services in conjunction with a routine periodic preventive exam as outlined below
- d. Routine immunizations (Including immunizations for foreign travel)

- e. Routine hearing exams (limit of one exam per Plan Member per Coverage Year)
- f. Routine vision exams (limit of one exam per Plan Member per Coverage Year)

Preventive Care Services	AGES												
Covered preventive care services are limited to once per plan member per coverage year unless otherwise indicated.													
All Members	> 5	≥ 11	≥ 12	≥ 18	≥ 19	≥ 20	≥ 45	≥ 50	≥ 55	≥ 60	≥ 75	> 80	
Hepatitis C (HCV) screening for people at high risk for infection and one-time screening for people born between 1945 and 1965	X	X	X	X	X	X	X	X	X	X	X	X	
Hepatitis B (HBV) screening for people at high risk for infection	X	X	X	X	X	X	X	X	X	X	X	X	
Obesity screening and counseling	X	X	X	X	X	X	X	X	X	X	X	X	
Chlamydia, gonorrhea and syphilis screening		X	X	X	X	X	X	X	X	X	X	X	
High intensity behavioral counseling to prevent sexually transmitted diseases		X	X	X	X	X	X	X	X	X	X	X	
Human immunodeficiencyvirus (HIV) screening		X	X	X	X	X	X	X	X	X	X	X	
Human papillomavirus (HPV) screening – once every 3 years beginning at age 30							X	X	X	X	X	X	
Depression screening			X	X	X	X	X	X	X	X	X	X	
Diabetes screening				X	X	X	X	X	X	X	X	X	
High blood pressure screening				X	X	X	X	X	X	X	X	X	
Alcohol misuse screening and counseling					X	X	X	X	X	X	X	X	
Healthy diet for hyperlipidemia/risk for diet related chronic disease counseling					X	X	X	X	X	X	X	X	
Tobacco use behavioral interventions and FDA approved pharmacotherapy for adults who use tobacco					X	X	X	X	X	X	X	X	
Lipid panel once every 5 years						X	X	X	X	X	X	X	
Aspirin to prevent Cardiovascular Disease (CVD) and colorectal cancer*								X	X	X			
Colorectal cancer screening options (one of the following): - Fecal immunochemical test with flexible sigmoidoscopyevery 5 years - Barium enema and flexible sigmoidoscopy every 5 years - CT Colonographyevery 5 years - Colonoscopyonce every 10 years - Stool-based tests : fecal occult blood test, fecal immunochemical test, FIT-DNA (e.g. Cologuard) once per year								X	X	X	X	X	
Lung cancer screening with history of smoking									X	X	X		
Herpes zoster/shingles vaccine one time only										X	X	X	
Intensive behavioral counseling interventions to promote a healthful diet and physical activity for adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors				X	X	X	X	X	X	X	X	X	

Children's Health	Birth	2	3	5	6	7	9	10	11	12	18	19	20	21
Expanded newborn screen (blood)	X													
Phenylketonuria (PKU) once at birth	X													
Evoked otoacoustic emissions (EOAE) once at birth	X													
Prophylactic eye medication for gonorrhea once at birth	X													
Congenital hypothyroidism screening – one time only between birth and 1 year	X													
Sickle cell disease screening – one time only between birth and 1 year	X													
Iron supplements – between 6-12 months*	X													
Autism screening	X	X												
Developmental screening – up to four screenings between birth and 36 months	X	X	X											
Psychosocial/Behavioral assessment – up to four assessments between birth and 36 months	X	X	X											
Pediatric vision screening	X	X	X	X										
Dental caries chemoprevention, oral fluoride*	X	X	X	X	X									
Lead level screening	X	X	X	X	X									
Human Immunodeficiency virus (HIV) screening if at increased risk for HIV	X	X	X	X	X	X	X	X						
Tuberculin skin testing (TB)	X	X	X	X	X	X	X	X	X	X	X			
Hepatitis C virus (HCV) screening for members at high risk	X	X	X	X	X	X	X	X	X	X	X			
Developmental surveillance	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Hematocrit or Hemoglobin screening	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Metabolic/Hemoglobin	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Lipid panel		X	X	X	X	X	X	X	X	X	X	X		
Alcohol and Drug use assessment									X	X	X	X	X	X
Men's Health						≥ 18	≥ 45	≥ 65	≥ 75	≥ 80				
Vasectomy sterilization procedure						X	X	X	X	X				
Abdominal Aneurysm screening – one time only								X						
Women's Health						≥ 9	≥ 11	≥ 19	≥ 21	> 26	≥ 40	≥ 45	≥ 55	≥ 80
FDA approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity							X	X	X	X	X	X	X	X
Breast cancer chemoprevention counseling and treatment*								X	X	X	X	X	X	X
Counseling and testing related to BRCA with family history								X	X	X	X	X	X	X
Papanicolaou smear (once every 3 years age 40-65)									X	X	X	X		
Mammogram											X	X	X	X
Breast cancer screening											X	X	X	X
Osteoporosis screening												X	X	X
Preconception and Prenatal Care														

Folic acid supplements for members planning or capable of pregnancy*			
Bacteriuria screening for pregnant female – once per pregnancy			
Hepatitis B screening for pregnant female – once per pregnancy			
HIV screening for pregnant female			
Iron deficiency screening for pregnant female*			
RH Incompatibility screening for pregnant female – twice per pregnancy			
Syphilis screening for pregnant female			
Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period and costs for the purchase or rental of breastfeeding equipment, which includes the following: • Purchase of non-hospital grade electric or manual breast pump, once per pregnancy, which includes breast pump supplies for nursing women; • Rental of a hospital grade pump requires a prescription and prior authorization after the 3rd month of rental and may include Member cost-sharing.			
Gestational diabetes screening for pregnant women after 24 weeks of gestation			
Aspirin to prevent preeclampsia after 12 weeks of gestation in women who are at high risk for preeclampsia *			
Immunizations – Frequency and specific age guidelines in accordance with the Advisory Committee on Immunization Practices	≤ 6	≥ 7	≥ 19
Diphtheria, Tetanus, Pertussis (Tdap)*	X	X	X
Hepatitis A*	X	X	X
Hepatitis B*	X	X	X
Influenza*	X	X	X
Measles, Mumps, Rubella (MMR)*	X	X	X
Meningococcal*	X	X	X
Pneumococcal*	X	X	X
Inactivated Poliovirus (IPV)*	X	X	
Rotavirus*	X		
Haemophilus Influenza Type B*	X		
Human papillomavirus (HPV)*		X	X
Varicella*		X	X

* Items noted with an asterisk may be covered under the outpatient Prescription Drug benefit.

If a diagnosis is indicated after a routine Preventive Care exam, the exam will be payable under the Routine Preventive Care benefit; however, all healthcare services related to the diagnosis will be payable as any other illness. Coverage for Plan Members having additional risk factors, exhibiting a Sickness, or symptoms is provided under the Hospital and Physician benefits.

24. **Rehabilitation Facility.** Treatment in a Rehabilitation Facility when the treatment cannot be safely provided on an Outpatient basis. Charges made

by an Inpatient Rehabilitation Facility are covered on the same basis as if the charges had been made by a general Hospital.

25. **Skilled Nursing Facility. This benefit applies to US Providers ONLY.** Charges by a Skilled Nursing Facility for confinement as an alternative to Hospital confinement. The same benefits available in a Hospital are available in a Skilled Nursing Facility when prescribed by the attending Physician and the confinement is due to an Injury or Sickness.

Benefits are available only as long as necessary for the proper care and treatment of the Plan Member. The Plan may require written certification by the attending Physician as to the continuing need for skilled nursing care.

Plan Members are eligible for benefits under this provision while recovering from a Sickness or Injury requiring services of an intensity less than those available in an acute general Hospital but greater than those available at the Plan Member's home.

Benefits are limited to the maximums set forth in the Schedule of Coverage.

26. **Surcharges.** Charges for state imposed surcharges.

NOTE: If the Plan contains an exclusion for sales tax or other tax, the exclusion shall not be applicable to any surcharges.

27. **Therapies and/or Treatments.** Fees of a Hospital, Physician or Health Care Professional for services used to promote recovery from a Sickness or Injury for the following therapies and/or treatments:

- a. **Cardiac Rehabilitation** – Cardiac rehabilitation is limited to Phase I and Phase II. Phase I cardiac rehabilitation is a medically supervised multidisciplinary program covered under the inpatient Hospital benefit. Phase II cardiac rehabilitation usually begins upon dismissal from the Hospital and may continue for two weeks to three months. It is Physician directed and closely supervised by paramedical personnel. The program components include carefully prescribed exercise, education, counseling and risk-factor modification.
- b. **Chemotherapy** - The treatment of malignant disease by chemical or biological antineoplastic agents.
- c. **Occupational Therapy** - The treatment of a physically disabled Plan Member by means of constructive activities designed and adapted to promote the restoration of the Plan Member's ability to

satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the Plan Member's particular occupational role.

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time. No Benefits are provided for diversional, recreational or vocational therapies (such as hobbies, arts and crafts).

- d. **Physical Therapy** - The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neuro-physiological principles, and devices. Such therapy is performed to relieve pain, restore maximum function and to prevent disability following Sickness, Injury or loss of a body part.
 - e. **Radiation Therapy** - The treatment of disease by x-ray, radium, radon, roentgen or radioactive isotope.
 - f. **Respiratory or Inhalation Therapy** - The treatment of a condition by the administration of medicines, water vapors, gases or anesthetics by inhalation.
 - g. **Speech Therapy** - Expenses for speech therapy for restorative or rehabilitative speech therapy for speech loss or impairment due to an Injury or Sickness other than a functional nervous disorder, or due to Surgery performed as the result of an Injury or Sickness. If the speech loss is due to a congenital anomaly, Surgery to correct the anomaly must have been performed prior to the therapy.
28. **X-Rays or Laboratory Tests.** X-rays or laboratory tests recommended by a Physician or surgeon for diagnosis of a Sickness or Injury. This includes charges for Pre-admission Testing.

SECTION J

ANNUAL OUT-OF-POCKET MAXIMUM BENEFIT

The Annual Out-of-pocket maximum is the total amount of Covered Expenses that are payable by the Plan Member, during a Calendar Year. It is comprised of the Copay and Coinsurance. The maximum is shown in the Schedule of Coverage.

The Network Annual Out-of-pocket maximum will **NOT** be used to satisfy the Out-of-Network Annual Out-of-pocket maximum, and vice versa.

The Annual Out-of-pocket maximum does **NOT** include:

1. Charges Incurred for services and supplies which are not covered by the Plan.
2. Charges in excess of the Usual, Customary and Reasonable Fee.
3. Charges Incurred in excess of any maximum benefit listed in the Plan.
4. Any penalty payable by the Plan Member for non-compliance with the Pre-certification provision.

SECTION K

SIARMED

In order to receive benefits under the Siarmed Option, a Plan Member must receive treatment from a Siarmed provider. The Plan offers a higher level of coverage for the expenses provided by Siarmed providers.

A listing of Siarmed providers is available at no charge.

Responsibility for use of Siarmed

It is the Plan Member's responsibility to use Siarmed providers if the Plan Member wants to receive the higher level of benefits provided under this Plan.

The Plan Member is responsible for the difference between the Usual, Customary and Reasonable Fee and billed charges whenever Covered Services under the Plan are provided by a Non- Siarmed healthcare provider.

Healthcare Provider Status. Enrolling in this Plan does not guarantee that a particular Healthcare Provider will remain a Siarmed Network Healthcare Provider or that a particular Healthcare Provider will provide Plan Members with Healthcare Services. Plan Members should verify a Healthcare Provider's status as a Siarmed Network Healthcare Provider each time Healthcare Services are received from the Healthcare Provider.

When a Healthcare Provider is no longer a Siarmed Network Healthcare Provider, Plan Members must either choose to receive Healthcare Services from among the remaining Siarmed Network Healthcare Providers or receive a lower level of benefits as described in the Schedule of Coverage.

SECTION L

CARE PROVIDED BY THE UNITED STATES GOVERNMENT

The Plan will reimburse for care rendered by the Veterans Administration for non-service connected disabilities, on the same basis as these services are otherwise covered by the Plan.

The Plan will reimburse for care rendered by the United States to military retirees and dependents who are covered by this Plan on an inpatient basis through a facility of the uniformed services, on the same basis as these services are otherwise covered under the Plan.

COORDINATION OF BENEFITS

The Plan contains a non-profit provision coordinating it with other Plans under which an individual is covered so that total benefits available will not exceed 100% of the Allowable Expense for the services. When this Plan pays second, it will pay, with respect to each claim submitted for payment, 100% of Allowable Expenses less whatever payments were actually made by the Plan (or Plans) that paid first.

An "Allowable Expense" means any health care service or expense, including coinsurance, copays or copayment and without reduction for any deductible, that is covered in full or in part by any of the Plan covering the person. Allowable Expenses do not include expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under this Plan.

"Claim Determination Period" means the time during any one benefit year when a person is covered and incurs charges for services or supplies covered under this Plan and one other plan.

As each claim is submitted, each plan determines its liability and pays or provides benefits based upon Allowable Expenses incurred during the Claim Determination Period. However, that determination is subject to adjustment as later Allowable Expenses are incurred during the same Claim Determination Period.

"Plan" means any plan providing health benefits or health services including but not limited to:

1. Group, blanket or franchise insurance coverage;
2. Group practices and other group pre-payment coverage;

3. Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans; and
4. Any coverage under governmental programs, such as Medicare, Tricare/CHAMPUS, and any coverage required or provided by any statute, such as no-fault auto insurance.

"Plan" shall not include:

1. School accident type coverage;
2. Hospital indemnity coverage; or
3. Individual insurance coverage.

EFFECT ON BENEFITS

Plans determine the sequence in which they pay benefits, or which plan pays first, by applying uniform order of benefit determination rules in a specific sequence. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC). Any Plan that does not use these same rules always pays its benefit first.

When two Plans cover the same person, the following order of benefit determination rules establish which Plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until the order of benefits is established. The rules are as follows:

Rule 1: Non-Dependent/Dependent

- A. The Plan that covers a person as an employee, retiree, member or subscriber (that is, other than as a dependent) pays first; and the Plan that covers the same person as a dependent pays second;
- B. There is one exception to this rule. If the individual is a Medicare beneficiary, then, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 1. Secondary to the plan covering the individual as a dependent; and
 2. Primary to the plan covering the individual as other than a dependent (e.g., a retired employee),

then the order of benefits is reversed so that the plan covering the individual as an employee, member, subscriber, or retiree is secondary and the other plan is primary.

Rule 2: Dependent Child Covered Under More Than One Plan.

- A. The Plan that covers the parent whose birthday falls earlier in the calendar year pays first; and the Plan that covers the parent whose birthday falls later in the calendar year pays second, if:
 - 1. the parents are married or living together;
 - 2. the parents are not separated (whether or not they ever have been married); or
 - 3. a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.
- B. If both parents have the same birthday, the Plan that has covered one of the parents for a longer period of time pays first; and the Plan that covered the other parent for the shorter period of time pays second.
- C. The word “birthday” refers only to the month and day in a calendar year, not the year in which the person was born.
- D. If the specific terms of a court decree state that one parent is responsible for the child’s health care expenses or health care coverage, and the Plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child’s health care services or expenses, but that parent’s spouse does, the Plan of the spouse of the parent with financial responsibility pays first. This rule applies to plan years commencing after the Plan is given notice of the court decree.
- E. If the parents are divorced, separated or not living together (whether or not they have ever been married), and there is no court decree allocating responsibility for the child’s health care services or expenses, the order of benefit determination among the Plans of the parents and their spouses (if any) is:
 - 1. The Plan of the custodial parent pays first;
 - 2. The Plan of the spouse of the custodial parent pays second; and

3. The Plan of the non-custodial parents pays third; and
4. The Plan of the spouse of the non-custodial parent pays last.

If the dependent child is covered under a Plan of an individual other than the parents, the order of benefits is determined as if those individuals were the parents of the child. The custody rule is applicable to anyone who has legal custody of the dependent child.

Rule 3: Active/Laid-off or Retired Employee

- A. The Plan that covers a person as an active employee, that is, an employee who is neither laid-off or retired, is primary. The Plan covering that same person as a retired or laid-off employee is secondary. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee.
- B. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- C. This rule does not apply if Rule #1 described above can be used to determine the order of benefits

This rule is applicable only in the rare situations when the same individual is covered under two plans, one as an active employee and the other as a retired or laid-off employee. This rule does not apply to an individual covered under his or her own Plan as either an active, retired, or laid-off employee and also as a dependent under another Plan. In those situations, Rule #1 should be applied.

Rule 4: Continuation Coverage

- A. If a person whose coverage is provided under a right of continuation under federal or state law (e.g. COBRA) is also covered under another Plan, the Plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the Plan providing continuation coverage to that same person pays second.
- B. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

This rule is applicable only to the rare situations when an individual is covered under both COBRA and non-COBRA plans as other than a dependent, or as a dependent of a individual who is covered under both plans as a non-dependent. In the majority of continuation coverage situations, two employee spouses are involved (one on COBRA and one on the basis as active employment). In this scenario, Rule #1 is applicable.

Rule 5: Longer/Shorter Length of Coverage

If none of the four previous rules determines the order of benefits, the Plan that covered the person for the longer period of time pays first; and the Plan that covered the person for the shorter period of time pays second.

Rule 6: None of the Above Rules Apply

If the preceding rules do not apply, the allowable expenses shall be shared equally between the Plans.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any other plan, the plan may without the consent of or notice to any persons release to, or obtain from, any insurance company or other organization or person any information with respect to any person which it deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan information as may be necessary to implement this provision.

FACILITY OF PAYMENT

Whenever payments which should have been made under the Plan in accordance with this provision have been made under any other plan, the Plan shall have the right, exercisable alone and at its sole discretion, to pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision and amounts so paid shall be deemed to be benefits paid under this Plan and to the extent of such payments for covered services, the Plan shall be fully discharged from liability.

SECTION M

MEDICARE SELECTION PROVISION

If the Employer has **less** than 20 Employees in the current Calendar Year, Medicare coverage is primary (and this Plan will be secondary) for active Employees age 65 or older and their Dependents 65 or older. This Plan will reduce payment by the amount paid or payable by Medicare.

If the Employer had 20 or **more** Employees in the current or preceding Calendar Year, Federal law requires that Medicare coverage be secondary to this Plan. The Plan Member has the option of rejecting this Plan thereby retaining Medicare as his/her primary coverage. If the Plan Member chooses Medicare as primary, the Employer can not provide any supplemental coverage. If the Plan Member rejects coverage under this Plan that choice must be made in writing to the Employer.

Federal law also mandates which plan is primary in the case of certain persons who are totally disabled or have end stage renal disease.

NOTE: This Plan will determine the primary and secondary payment of claims based on the current rules and regulations set forth by Medicare.

SECTION N

GENERAL PROVISIONS

The Plan and The Master Plan Document

The Plan Sponsor has filed the Master Plan Document in the office of the Human Resource Department, which can be inspected at any time during normal working hours by any Plan Member.

The Plan is a legal entity. Legal notices may be filed with, and legal process served upon, the Plan Administrator.

Plan Administrator

The Plan Administrator as used herein shall be the person or firm responsible for the day to day functions and management of the Plan. The Plan Administrator is the Employer.

The construction and interpretation of the Plan are vested with the Plan Administrator, in its absolute discretion, including, without limitation, the determination of benefits, eligibility and interpretation of Plan provisions. The Plan Administrator will endeavor to act, whether by general rules or by particular decisions, so as to treat all persons in similar circumstances without discrimination. All such decisions, determinations and interpretations shall be final, conclusive and binding upon all parties having an interest in the Plan.

Named Fiduciary

The Named Fiduciary is the Plan Administrator and has the authority to control and manage the operation and administration of the program. A participant under the Plan will not receive Plan benefits unless the Plan Administrator determines that the participant is entitled to such benefits.

Claims Administrator

The Claims Administrator will provide technical services in connection with operation of the coverage and performing other functions.

The Plan Is Not An Employment Contract

The Plan shall not be deemed to constitute a contract between the Employer and any Employee or be a consideration for, or an inducement or condition of, the employment of an Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provision of any collective bargaining agreements which may be made by the Employer with the bargaining representative of any Employees.

Exchange Of Information

The Plan will promptly provide to appropriate Federal, state and local law enforcement authorities and to other appropriate health plans:

1. Information indicating a potential violation of civil, criminal, or administrative laws relating to fraud and abuse with respect to health plans.
2. Information requested by Federal, state, or local law enforcement agencies which the agency states is relevant to an investigation, audit, evaluation, or inspection under the Federal Fraud and Abuse Control Program.
3. Information which would assist in the identification of potential violations or assist in the identification of areas requiring investigation, audit, evaluation, or inspection. Such information may include:
 - a. Surveys; Quality assurance reviews;
 - b. Provider and patient profiles;
 - c. Utilization review, and
 - d. Other similar analyses.

Alternative Treatment

The Plan Administrator has the right to approve coverage for treatment, procedures or facilities that are not normally covered under the Plan, if the Plan Administrator feels that this alternative treatment, procedure or facility offers a cost-effective method of treating the Plan Member's condition. Such approval in no way obligates the Plan Administrator to approve such coverage in the future, nor does it obligate the Plan

Administrator to approve of Alternative Treatment for any other Plan Member. Each case will be decided on its own merits.

Free Choice of Physician

Each Plan Member has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. The Plan Member, together with his Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The Network providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any Network provider.

Qualified Medical Child Support Orders (QMCSO)

The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a "Qualified Medical Child Support Order" ("QMCSO") if such an individual is not already covered by the Plan as an eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

"Alternate Recipient" shall mean any child of a Plan Member who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Plan Member's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Plan Member.

Upon receiving a Medical Child Support Order (Order), the Plan Administrator shall, as soon as administratively possible:

1. Notify the Plan Member and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and
2. Make an administrative determination if the Order is a QMCSO and notify the Plan Member and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice (Notice), the Plan Administrator shall:

1. Notify the state agency issuing the Notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:

- a. Whether the child is covered under the Plan; and
 - b. Either the Effective Date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator shall:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and
2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

A Plan Member may request at any time a copy of QMCSO procedures from the Plan without charge.

Other Service Plan Contracts

If any Plan Member is covered under more than one Plan, the coverage that would be provided under this Plan in the absence of this provision shall be reduced to the extent necessary so that the sum of such reduced coverage, together with the benefits, if any, that are paid or payable under such other Plan contract for health service shall not exceed the total charges for the health service.

Worker's Compensation Notice

The Plan is not in lieu of, is not in any way subject to, and does not affect any requirement for coverage by worker's compensation insurance.

Erroneous Payment Refund Provision

Covered Expenses are occasionally paid erroneously by the Plan (i.e., paid more than once; incorrectly paid under the Plan's terms, conditions, limitations or exclusions; or conditionally paid pending further review). An Employee, Dependent, or health care service provider receiving such an overpayment or erroneous payment shall, upon

discovery or notice thereof, return such payment to the Plan within 30 days of discovery or demand. Neither the Plan nor the Plan Administrator shall have any obligation to make any other payment of the bill prior to refund by the health care provider, Employee or Dependent. A health care provider may not apply an erroneous or duplicate payment to another bill balance or any other Dependent. The Plan Administrator shall have the exclusive right to choose who will repay it for an overpayment or erroneous payment (i.e., including but not limited to the Employee, Dependent, health care service provider or another health benefit plan). If the Plan elects to seek refund from the Employee or Dependent, recovery of the overpaid amount shall, at the Plan Administrator's option, be reimbursed in a lump-sum, time payments or deducted from future claims presented for processing.

Health care service providers accepting payment for services from the Plan, in consideration of such payments, further agree to submit claims for reimbursement in strict accord with their state's health care practice acts, ICD-10, or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator.

Any claims not paid in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur a pre-judgment interest rate of 1 ½% per month. The Plan shall be entitled to litigation costs and actual attorney fees in the event it becomes necessary to institute suit to recover duplicate or erroneous payments or payments of improperly billed charges.

Conformity With Applicable Law

This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document.

Clerical Error

Clerical errors, such as inaccurate transcription of premiums, Effective Dates, termination dates, or such as erroneous mailings, shall not change the rights or obligations of any party under the Plan and shall not operate to grant additional benefits to Plan Members.

Fraud

The following actions by any Plan Member, or a Plan Member's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for that Plan Member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Plan Member in the Plan;
2. Attempting to file a claim for a Plan Member for services which were not rendered or drugs or other items that were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

No Waiver

The failure of the Plan Administrator to strictly enforce any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Plan Administrator reserves the right to strictly enforce each and every provision of this Plan at any time regardless of the prior conduct of the Plan Administrator and regardless of the similarity of the circumstances or the number of prior occurrences.

Plan Contributions

The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed by each Plan Member.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be free to determine the manner and means of funding the Plan. The amount of the Plan Member's contribution will be determined from time to time by the Plan Administrator.

Booklets

The Plan Administrator has issued to each Employee an individual booklet, which summarizes the benefits to which the person is entitled, to whom benefits are payable, and the provisions of the Plan affecting the Plan Members. The booklet is intended to satisfy any requirements for a Summary Plan Description.

Entire Plan

The Plan including any amendments, the Schedule of Coverage, any other applicable schedules, the attached papers, the application of the Employer for any reinsurance policy, and the individual applications, if any, of the Employees and eligible Dependents, constitute the entire description of benefits between the parties and any statement made by the Employer or by any Employee shall not, in any way, change such benefits.

All statements made by the Employer or by a Plan Member shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this Plan or be used in defense of a claim unless they are contained in writing and signed by the Employer or by the Plan Member, as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such contest.

Plan Modification and Amendment

The City Manager of the Company shall be empowered to amend this Plan or any benefit under this Plan at any time by a written instrument signed by the City Manager. An increase or decrease in Plan benefits will become effective as of the date specified in the Plan or in an applicable amendment.

The Plan will furnish each Plan Member with a summary of any material reductions in covered services or benefits not later than 60 days after the effective date of such change.

Plan Termination

The City Manager of the Company may terminate the Plan at any time. Upon termination, the rights of the Plan Members to benefits are limited to claims Incurred and due up to the date of termination. Any termination of the Plan will be communicated to Plan Members.

Assignment

The Plan Member's benefit payments may not be assigned except by consent of the Company to other than suppliers of medical services.

Automatic Assignment

All medical expense benefits payable under this Plan shall be paid to the medical service provider, unless the claimant furnishes proof of payment of the medical expenses at the time the claim is filed with the Claims Administrator, in which case the benefits shall be paid to the claimant. The Plan is discharged from liability to the extent of such amounts paid to the claimant for Covered Expenses.

Physical Examination

The Plan at its own expense shall have the right and opportunity to examine any Plan Member, whose Injury or Sickness is the basis of a claim, as often as it may reasonably require while a claim is pending.

Disclosure Of Electronic Protected Health Information (“Electronic PHI”) To The Plan Sponsor For Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

1. Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI; and
4. Report to the Plan any Security Incident of which it becomes aware.

Any terms not otherwise defined shall have the meanings set forth in the Security Standards.

Privacy Standards

1. Disclosure of Summary Health Information to the Plan Sponsor.

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

“Summary Health Information” may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

2. Disclosure of Protected Health Information (“PHI”) to the Plan Sponsor for Plan Administration Purposes.

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

- a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);
- b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
- d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- e. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);
- f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

- g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
- h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);
- i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- j. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - i. The following Employees or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

HR Department
City Manager
 - ii. The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
 - iii. In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Document relating to use and disclosure of PHI, the Plan Sponsor shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

“Plan Administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan Administration” functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

3. Disclosure of Certain Enrollment Information to the Plan Sponsor.

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan.

4. Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage.

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

5. Other Disclosures and Uses of PHI.

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

SECTION O

SUBROGATION/RIGHT OF REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Members, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Member(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage"). Plan Member(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Plan Member(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Member(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Plan Member(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Plan Member shall be a trustee over those Plan assets.

In the event a Plan Member(s) settles, recovers, or is reimbursed by any Coverage, the Plan Member(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Member(s). If the Plan Member(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Member(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Member(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Plan Member(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Member(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Plan Member(s) fails to so pursue said rights and/or action.

If a Plan Member(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Member(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Plan Member is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Plan Member is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Plan Member(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Plan Member(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

the Plan Member(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Member's/Plan Members' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Member(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, without regard to whether the Plan Member(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Member's/Plan Members' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Plan Member are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Plan Member's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Plan Member is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Member(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Member(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, disease or disability.

Plan Member is a Trustee Over Plan Assets

Any Plan Member who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Plan Member understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Plan Member is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Member obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Plan Member disputes this obligation to the Plan under this section, the Plan Member or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Plan Member, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

If at the time of Injury, Sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Plan Member(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Member(s), such that the death of the Plan Member(s), or filing of bankruptcy by the Plan Member(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Plan Member(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Plan Member(s) and all others that benefit from such payment.

Obligations

It is the Plan Member's/Plan Members' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.

7. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Member may have against any responsible party or Coverage.
8. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
9. In circumstances where the Plan Member is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Member obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
10. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Plan Member over settlement funds is resolved.

If the Plan Member(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Plan Member(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Member(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Member's/Plan Members' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Plan Member and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Plan Member's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Plan Member(s) in an amount equivalent to any outstanding amounts owed by the Plan Member to the Plan. This provision applies even if the Plan Member has disbursed settlement funds.

Minor Status

In the event the Plan Member(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

SECTION P

CLAIM/APPEAL PROCEDURES

The procedures outlined below must be followed by Plan Members ("claimants") to obtain payment of health benefits under this Plan.

All claims and questions regarding health claims should be directed to the Claims Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the claimant is entitled to them. The responsibility to process claims in accordance with the Master Plan Document and summary plan description may be delegated to the Claims Administrator; provided, however, that the Claims Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion. The Plan Administrator has retained the services of an independent third party administrator, EBSO, Inc. ("Claims Administrator") to provide technical services, including the processing of claims.

Each Plan Member claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator, in its sole discretion may require, written proof that the expenses were incurred and that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the claimant has not incurred a Covered Expense or that the benefit is not covered under the Plan, or if the claimant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

Under the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

Definitions

Words which are capitalized in this document are either defined below or in the Master Plan Document (see Definitions of General Terms, General Information and General Provisions) and summary plan description.

Pre-service Claims:

A "Pre-service Claim" arises when there is a claim for a benefit under the Plan and the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A "Pre-service Urgent Care Claim" arises when there is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant

or the claimant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

It is important to remember that, if a claimant needs medical care for a condition which could seriously jeopardize his life, there is no need to contact the Plan for prior approval. The claimant should obtain such care without delay.

Further, if the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Concurrent Claims:

A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the claimant requests extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Post-service Claims:

A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed

Health claims must be filed with the Claims Administrator within six months of the date charges for the service were incurred. However in no event, except in the absence of legal capacity, will claims be accepted later than 12 months from the date the charge in question was incurred. Charges are considered incurred when treatment or care is given or supplies are provided. **Claims filed later than that date shall be denied.**

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Utilization Review Organization in accordance with the Plan's Utilization Review procedures.

However, a Post-service Claim is considered to be filed when the following information is received by the Claims Administrator, together with a Form HCFA, Form UB92 or Form ADA:

1. The date of service;
2. The date the Injury or Sickness began;
3. The name, address, telephone number and tax identification number of the provider of the services or supplies;
4. The place where the services were rendered;
5. The diagnosis and procedure codes;
6. The amount of charges;
7. The name of the Plan and Plan ID #;
8. The name and home address of the Employee;
9. The Employee's social security number;
10. The name and home address of the patient; and
11. The patient's social security number.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Utilization Review Organization will determine if enough information has been submitted to enable proper consideration of the Pre-service Claim or Pre-service Urgent Claim. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the post-service claim. If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within 45 days (or by the Utilization Review Organization within 48 hours in the case of Pre-service Urgent Care Claims) from receipt by the claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

NOTE: The Plan does not consider inquiries about benefits, eligibility or the circumstances under which benefits might be paid, to be claims. An inquiry does not become a claim unless the proper claim procedure is followed. Further, questions concerning eligibility for benefits, such as calls from providers of medical services, are NOT ever considered claims.

Timing of Claim Decisions

The Plan Administrator shall notify the claimant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

Pre-service Urgent Care Claims:

If the claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim. The claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded the claimant to provide the information.

Pre-service Non-urgent Care Claims:

If the claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the claimant (if additional information was requested during the extension period).

Concurrent Claims:

Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The claimant will be notified sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving Urgent Care and decided within the Urgent Care timeframe.

Request by Claimant Involving Non-urgent Care. If the Plan Administrator receives a request from the claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

Post-service Claims:

If the claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If the claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the claimant will be notified of the determination by a date agreed to by the Plan Administrator and the claimant.

Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service Urgent Care Claims.

Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a claimant with a notice, either in writing or electronically (or, in the case of Pre-service Urgent Care Claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), containing the following information:

1. A reference to the specific portion(s) of the Master Plan Document and summary plan description upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the claimant's right to bring a civil action following an adverse benefit determination on final review;
5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;
6. The identity of any medical, dental or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the claimant, free of charge, upon request);
8. In the case of denials based upon a medical judgment (such as whether the treatment is Medical Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided to the claimant, free of charge, upon request; and
9. In a claim involving Urgent Care, a description of the Plan's expedited review process.

Requested copies will be provided to the claimant within a reasonable period of time, not to exceed 30 days from the date the Plan receives the written request for copies.

Appeal of Adverse Benefit Determinations – Internal Review

A. Procedures for Review of Adverse Benefit Determinations

In cases where a claim for benefits is denied, in whole or in part, and the claimant believes the claim has been denied wrongly, the claimant may appeal the denial and review relevant documents. The claims procedures of this Plan provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. Claimants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination. If the claimant does not appeal on time, he/she will lose the right to file suit in court and will have failed to exhaust the Plan's internal administrative appeal procedures, which is generally a prerequisite to bringing suit;
2. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. For a review that is independent from the initial adverse benefit determination and is conducted by an appropriate named fiduciary of the Plan who is not the same individual who decided the claimant's initial adverse benefit determination and who is not also that individual's subordinate;
4. For a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
5. That, if an adverse benefit determination is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with an independent health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is not the same person as the health care professional consulted in connection with the initial adverse benefit determination;
6. For the identity of medical/vocational experts consulted in connection with the appeal, even if the Plan did not rely upon their advice; and
7. In an Urgent Care Claim, for an expedited review process pursuant to which:
 - a. A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

- b. All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

B. Requirements for Appeal

The claimant must file the appeal in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) within 180 days following receipt of the notice of an initial adverse benefit determination. For Pre-service Urgent Care Claims, if the claimant chooses to orally appeal, claimant may telephone: Appeal Dept. EBSO, Inc. at 800-558-7798. To file an appeal in writing, the claimant's appeal must be addressed as follows and mailed and/or faxed to the following number: *Attention: Appeal Dept. c/o EBSO, Inc. 215 Stanford Parkway, Findlay, OH 45840. Fax (419) 423-5834.*

It shall be the responsibility of the claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee;
2. The name of the claimant;
3. The Employee's social security number;
4. The claimant's social security number;
5. The group name and identification number;
6. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories which support this claim if the claimant fails to include them in the appeal;**
7. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
8. Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.

If the claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

C. Notification of Benefit Determination on Review

The Plan Administrator shall notify the claimant of the Plan's benefit determination on review within the following timeframes:

Pre-service Urgent Care Claims: As soon as possible, taking into account the medical

exigencies, but not later than 72 hours after receipt of the appeal.

Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – Pre-service Urgent, Pre-service Non-urgent or Post-service.

Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

D. Manner and Content of Notification of Adverse Benefit Determination on Review.

The Plan Administrator shall provide a claimant with notification, with respect to Pre-service Urgent Care Claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Master Plan Document and summary plan description on which the denial is based;
3. The identity of any medical, dental or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided free of charge upon request;

7. A description of any available External Review process and how to initiate an External Review;
8. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office or the Plan Administrator."

If, for any reason, the claimant does not receive a written response to the appeal within the appropriate time period set forth above, the claimant may assume that the appeal has been denied and the Plan's internal review procedures have been exhausted.

Appeal of Adverse Benefit Determinations – External Review

A. Overview

If the claim is denied, the claimant may be eligible to have his/her claim reviewed by an Independent Review Organization (IRO) pursuant to a process called "External Review." Generally, External Review is available only after the claim denial has been upheld after the final level of appeal under the Plan. The claimant may, however, in limited circumstances have the right to have the claim reviewed by an IRO prior to exhausting the Plan's appeal process. See **Expedited External Review** for further details.

B. Request for Review

External Review is available only for medical claims (excluding dental and vision) that involve medical judgment (including, for example, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination as to whether a treatment is experimental or investigational) and for rescissions of coverage (i.e. retroactive cancellations of coverage because of the Plan Member's fraud or intentional misrepresentation of a material fact regarding eligibility for coverage).

Federal government agency guidance may further limit or broaden the scope of External Review. The Plan will provide an External Review process in accordance with applicable guidance.

A request for External Review must be filed in accordance with the instructions contained in the claimant's appeal denial notice and must be received not later than four months after the date he/she receives the appeal denial notice. If there is no corresponding date four months after the date of the appeal denial notice, then the request must be filed by the first day of the fifth month following receipt of the notice. For example, if the date of the denial notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

C. Preliminary Review

Within five business days after receiving the claimant's External Review request, the Plan Administrator will complete a preliminary review to determine whether his/her request is complete and eligible for External Review. That preliminary review will determine: whether the claimant was covered under the Plan at the time the item or service was requested or provided; whether the final denial of his/her appeal related to the claimant's failure to meet the Plan's eligibility requirements; whether the claimant exhausted the Plan's internal appeal process (or are not required to exhaust the process); and whether the claimant has provided all the information and forms required to process an External Review.

Within one business day after the completion of the preliminary review, the Plan Administrator will notify the claimant of one of the following:

1. That his/her request is complete, but she/he is not eligible for external review. This notice will state the reasons for the ineligibility and provide contact information for the Employee Benefits Security Administration.
2. That his/her request is incomplete, but may still be eligible for external review. This notice will describe the information or materials needed to complete the request. The claimant will be permitted to provide the required information by the later of: (a) the last day of the four month filing period or (b) 48-hours after receipt of the notice.
3. That his/her request is complete and eligible for external review.

D. Referral to IRO

If the claimant's request for External Review is complete and eligible, the Plan Administrator will assign a qualified IRO to conduct the External Review and within five business days after making the assignment will provide the IRO with the documents and information the Plan Administrator considered in making its final appeal denial.

The claimant will have at least 10 days to submit additional information to the IRO. If the claimant submits additional information, the IRO will send that information to the Plan and the Plan may reconsider its determination. If the Plan decides, on reconsideration, to reverse its benefits denial and provide coverage or payment, then the external review can be terminated.

If the Plan does not reverse its determination, the IRO will review all of the information and documents timely received. In reaching a decision the IRO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeal process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate will

consider the following in reaching a decision: the claimant's medical records; the attending health care professional's recommendation; reports from the appropriate health care professionals and other documents submitted by the Plan Administrator, the claimant's treating provider; the terms of the Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan; appropriate practice guidelines; any applicable clinical review criteria developed and used by the Plan; and the opinion of the IRO's clinical reviewer(s).

The IRO must provide written notice to the claimant and the Plan Administrator of the final External Review decision within 45 days after the IRO receives the request for External Review. If the IRO reverses the Plan's determination, the Plan must immediately provide coverage or payment for the claim.

E. Expedited External Review

Under the following circumstances, the claimant may be eligible to file for an expedited External Review:

1. If the claimant receives a claim denial that involves a medical condition for which the timeframe for completion of an expedited internal appeal with the Plan Administrator would seriously jeopardize the claimant's life or health, or that would jeopardize the claimant's ability to regain maximum function, and the claimant has filed a request for an expedited internal appeal; or
2. If the claimant receives a final appeal denial from the Plan Administrator and: he/she has a medical condition for which the timeframe for completion of a standard external appeal would seriously jeopardize his/her life or health, or would jeopardize his/her ability to regain maximum function; or if the final claim denial concerns an admission, availability of care, continued stay, or health care item or service for which the claimant has received emergency services but have not been discharged from a facility.

Immediately upon receipt of the request for an expedited External Review, the Plan Administrator will complete a preliminary review of the claimant's request in order to determine his/her eligibility for expedited External Review. Immediately after completion of the preliminary review, the Plan Administrator will issue the claimant a written notification of his/her eligibility for expedited External Review. If the claimant's request is complete but not eligible for External Review, the notice will include the reasons for ineligibility. If the claimant's request is incomplete, the notice will describe the information or materials needed to make the request complete and the claimant will have an opportunity to complete the request.

Upon a determination that a request is eligible for expedited External Review, the Plan Administrator will assign an IRO for review and transmit all necessary documents and

information to the IRO. The IRO must provide notice, to the claimant and the Plan Administrator of the final External Review decision as expeditiously as possible, but in no event later than 72 hours after the IRO receives the request for the expedited External Review.

All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.

Appointment of Authorized Representative

A claimant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the claimant must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. **In the event a claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the claimant, unless the claimant directs the Plan Administrator, in writing, to the contrary.**

THE PPO IS ADMINISTERED BY:

**BCBS of Arizona
Multiplan wrap
In Mexico, SIARMED**

The Plan will at all times be in compliance with PPACA rules and regulations. PPACA requires that benefits that are offered by the Plan that are "Essential Health Benefits" as defined by the United States Department of Health And Human Services may not be restricted to less than a certain annual amount. If a major medical benefit of the Plan has a plan maximum below that amount, the Plan will continue to pay benefits for the Essential Health Benefit components of that benefit even though such payments would exceed the plan maximum for that benefit, but only until the Coverage Year Maximum Payment Amount of the Plan is paid.

This plan may provide a greater discounts / reimbursement for services received through the PPO Provider Selected Hospital and Outpatient Facility. Refer to the **INCENTIVE PROGRAM FOR PPO PROVIDER SELECTED HOSPITAL/OUTPATIENT FACILITY AKA WIN/WIN INCENTIVE PROGRAM** for more information and a list of providers.

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Acupuncture	80% after Deductible	60% after Deductible	LIMITED to a maximum of 26 visits per Coverage Year.
Ambulance Services -Air and Ground	80% after Deductible	80% after Deductible	
Amino acid-based formula	25% after Deductible	25% after Deductible	LIMITED to supplies not covered under the Prescription Drug Card Benefit. The maximum annual benefit for amino acid based formula to treat eosinophilic gastrointestinal disorder is \$20,000 per Plan Member per Coverage Year.
Chiropractic Care	100% after a \$15 Copay per visit (Deductible waived)	60% after Deductible	Includes x-rays, manipulations, supportive care, and maintenance care. LIMITED to a maximum of 20 visits per Coverage Year.
Dental Hospitalization and Dental Services Office Visits	80% after Deductible	60% after Deductible	Diagnostic procedures & treatment of TMJ are LIMITED to a Lifetime maximum benefit payment of \$300.
Durable Medical Equipment, Prosthetics, Orthotics and Disposable Supplies	80% after Deductible	60% after Deductible	Hearing aids are LIMITED to one per Coverage Year.
Emergency Services and Urgent Care Services			In an Emergency, as defined by the Plan, Non-PPO Covered Expenses will be paid at the PPO level.
Emergency visit	80% (Deductible waived).	80% (Deductible waived).	
Urgent Care	100% after a \$30 Copay per visit (Deductible waived)	60% after Deductible	

City of San Luis
EMPLOYEE BENEFIT TRUST DENTAL BENEFIT PLAN – Mexico Coverage

PLAN DOCUMENT and
SUMMARY PLAN DESCRIPTION

EBSO GROUP NUMBER: SLS0001

Effective: July 1, 2018

TABLE OF CONTENTS

SECTION A	2
INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION	2
<i>Introduction and Purpose</i>	2
<i>General Plan Information</i>	3
SECTION B	5
SCHEDULE OF COVERAGE	5
SECTION C	6
DEFINITIONS OF GENERAL TERMS	6
SECTION D	15
ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE	15
EMPLOYEE ELIGIBILITY DATE	15
EMPLOYEE EFFECTIVE DATE OF COVERAGE	15
DEPENDENT ELIGIBILITY DATE	15
DEPENDENT EFFECTIVE DATE OF COVERAGE	16
CHANGE IN STATUS	16
SPECIAL ENROLLMENT PERIOD	17
OPEN ENROLLMENT PERIOD	18
CHOOSING PLAN OPTIONS	19
TERMINATION OF INDIVIDUAL COVERAGE	19
SECTION E	22
CONTINUATION OF COVERAGE UPON INDIVIDUAL TERMINATION (COBRA)	22
SECTION F	35
UNIFORMED SERVICES CONTINUATION AND REINSTATEMENT PROVISION	35
SECTION G	37
GENERAL LIMITATIONS AND EXCLUSIONS	37
SECTION H	40
DENTAL BENEFITS	40
<i>Covered Dental Expenses</i>	40
SECTION I	42
CARE PROVIDED BY THE UNITED STATES GOVERNMENT	42
COORDINATION OF BENEFITS	42
EFFECT ON BENEFITS	43
SECTION J	47
MEDICARE SELECTION PROVISION	47
SECTION K	48
GENERAL PROVISIONS	48
<i>The Plan and The Master Plan Document</i>	48
<i>Plan Administrator</i>	48
<i>Named Fiduciary</i>	48
<i>Claims Administrator</i>	48
<i>The Plan Is Not A Contract</i>	49

<i>Exchange Of Information</i>	49
<i>Alternative Treatment</i>	49
<i>Free Choice of Physician</i>	50
<i>Qualified Medical Child Support Orders (QMCSO)</i>	50
<i>Other Service Plan Contracts</i>	51
<i>Worker’s Compensation Notice</i>	51
<i>Erroneous Payment Refund Provision</i>	51
<i>Conformity With Applicable Law</i>	52
<i>Clerical Error</i>	52
<i>Fraud</i>	53
<i>No Waiver</i>	53
<i>Plan Contributions</i>	53
<i>Plan Modification and Amendment</i>	54
<i>Automatic Assignment</i>	55
<i>Physical Examination</i>	55
<i>Disclosure Of Electronic Protected Health Information (“Electronic PHI”) To The Plan Sponsor For Plan Administration Functions</i>	55
<i>Privacy Standards</i>	55
SECTION L	59
SUBROGATION/RIGHT OF REIMBURSEMENT	59
SECTION M	66
CLAIM/APPEAL PROCEDURES	66

ESTABLISHMENT OF THE MASTER PLAN DOCUMENT

Effective July 1, 2018, the Plan Sponsor establishes City of San Luis Employee Benefit Trust Dental Benefit Plan - Mexico Coverage (the "Plan") to provide self-funded benefits for its Employees and their Dependents.

This Plan replaces the Plan Sponsor's previous plan of dental benefits. It is the intent of the Plan Sponsor to provide continuous eligibility and coverage from the previous plan to this Plan.

The Plan Sponsor hereby adopts this Plan Document as the written description of the Plan.

Disclaimer Of Claims Administrator

EBSO, Inc. has prepared this document for your review and consideration; however, we are not legal counsel, nor are we in the business of practicing law. As your Plan's fiduciary, you are fully responsible for all legal issues that concern the Plan. If you are not an expert in this area, we urge you to hire an attorney to help you review this Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Date

Signature

Print or Type Name and Title

Witness Signature

Print or Type Witness Name

SECTION A

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

City of San Luis, the Employer, has established the City of San Luis Employee Benefit Trust Dental Benefit Plan – Mexico Coverage in order to provide comprehensive dental benefits for Employees, and their Dependents.

The City of San Luis Employee Benefit Trust Dental Benefit Plan – Mexico Coverage is a self-insured public sector plan within the meaning of Arizona Statute 11-981 (hereinafter “Plan”). The Dental Plan is not an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). Any resemblance to an ERISA plan shall not be construed to mean it is an ERISA plan. The Dental Plan is a self-insured medical plan intended to meet the requirements under Sections 105(b), 105(h) and 106 of the Internal Revenue Code of 1986 so the portion of the cost for coverage paid by the Employer is not taxable income to the Employee and any benefits received through the Dental Plan are not taxable income to the Employee. This Dental Plan is a group health plan for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and shall be administered in a manner consistent with HIPAA.

The Plan Sponsor has established the Plan for the benefit of eligible employees and their eligible dependents, on the terms and conditions described herein. The Plan Sponsor’s purpose in establishing the Plan is to help to offset, for eligible Employees, the economic effects arising from a non-occupational Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

This Plan is a non-grandfathered plan under Patient Protection and Affordable Care Act (PPACA) and Health Care and Education Reconciliation Act (HCERA), collectively referred to as Health Care Reform.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain medical expenses. The Plan Document is maintained by the Plan Sponsor and may be inspected at any time during normal working hours by any Plan Member.

The Schedule of Coverage is meant only as a summary of benefits. For more details about the benefits, check the Table of Contents and refer to the specific section in the booklet for complete terms and conditions.

This Plan covers only those expenses incurred in connection with non-occupational injuries or disease.

The Employer has contracted with the Claims Administrator to perform certain consultative and management services related to the Plan. The Employer retains ultimate authority for the Plan.

Certain words in this Plan have precise meanings and will be capitalized and defined in the Definition section or where used in the text, so that you will pay special attention to them.

New Rescission of Coverage Rules. Under this Dental Plan, coverage may be retroactively cancelled or terminated if you act fraudulently or make material misrepresentations of fact. It is your responsibility to provide accurate information and to make accurate and truthful statements including information and statements regarding familial status, age, relationships, etc. In addition, it is your responsibility to update previously provided information and statements. Failure to do so may result in your coverage, including the coverage of those provided coverage through you, being cancelled and such cancellation may be retroactive.

General Plan Information

Name of Plan:	City of San Luis Employee Benefit Trust Dental Plan – Mexico Coverage
Plan Sponsor:	City of San Luis 1090 E. Union Street San Luis, AZ 85349 928-341-8547
Plan Administrator: (Named Fiduciary)	City of San Luis 1090 E. Union Street San Luis, AZ 85349 928-341-8547
Plan Sponsor ID No. (EIN):	86-0376164
Fiscal Year:	January 1 through December
Plan Number:	501
EBSO Group Number:	SLS001
Type of Administration:	Self-funded Dental Plan

Sources and Methods of
Contributions to the Plan:

The Employer and the Employee share in the cost of the Plan. The Employer's contribution is made from his general assets and the Employee's contribution is made from payroll deductions. The Employer will provide a schedule of the applicable premiums during the initial enrollment, during open enrollment periods, on the Plan's annual renewal date and upon request.

All contributions shall be held in the Trust.

The Plan is "self-insured" which means that benefits are paid with assets from the Trust established by the Employer to pay benefits under the Dental Plan.

Name of Trust

City of San Luis Employee Benefit Trust

Trustees

For current information on Trustees, please refer to the Agreement and Declaration of Trust for City of San Luis Employee Benefit Trust

Claims Administrator:

EBSO, Inc.
215 Stanford Pkwy
Findlay, OH 45840
Phone Number 800-558-7798

Please Note: EBSO, Inc. performs claims processing services pursuant to a contract, it does not insure benefits under the Dental Plan.

Agent for Legal Services:

City of San Luis
1090 E. Union Street
San Luis, AZ 85349
928-341-8547

SECTION B SCHEDULE OF COVERAGE

NOTE: THIS IS ONLY A SUMMARY, SPECIFIC SERVICES AND SUPPLIES MAY BE SUBJECT TO COPAYS, MAXIMUM BENEFIT PAYMENTS, USUAL, CUSTOMARY AND REASONABLE FEES AND/OR EXCLUSIONS AND LIMITATIONS.

NOTE: Benefits under this Plan will be paid only if the Plan Administrator decides in his/her discretion that the individual is entitled to them.

DENTAL BENEFITS – NETWORK ONLY

Copays

Class I Services – Diagnostic and Preventive Care	\$10
Class II Services - Basic Services	\$35
Class III Services - Major Services	\$50
Class IV Services – Orthodontics	None

Payment Percentages after Copay is met

Class I Services – Diagnostic and Preventive Care	100%
Class II Services - Basic Services	100%
Class III Services - Major Services	100%
Class IV Services – Orthodontics	50%

Maximum Benefits

Per Calendar Year for Class I, II & III Services, combined	\$1,000
Per Lifetime for Class IV Services	\$1,000

NOTE: Orthodontic Services are **LIMITED** to Dependent children less than 19 years of age. Dependent children must be covered under the Plan for 12 consecutive months before orthodontic services are available.

THE NETWORK IS ADMINISTERED BY: SIARMED

The only Out-of-Network providers covered under this Plan are United States providers. All other Out-of-Network providers are NOT covered.

SECTION C

DEFINITIONS OF GENERAL TERMS

When used and capitalized in this document, these terms have the following definitions. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of the Plan Document for that information.**

ALLOWED CHARGE means the maximum dollar amount eligible for payment for a procedure or service as determined by the Plan. This includes billed charges, contracted amounts or Usual, Customary and Responsible Fees, depending on the Dental Provider's relationship with the Plan and/or the dental services provided.

CALENDAR YEAR means the period from January 1 through the following December 31.

CALENDAR YEAR MAXIMUM BENEFIT means the total dollar amount of Covered Expenses a Plan Member may receive during a Calendar Year while enrolled under this Dental Plan. The Maximum Calendar Year Benefit does not include amounts which are the Plan Member's responsibility.

COINSURANCE means the charge a Plan Member must pay for certain Covered Services until the Calendar Year Maximum Benefit has been reached. Covered Services subject to Coinsurance and the amounts are listed in the Schedule of Coverage. Coinsurance is a percentage of the Allowed Charge. In some instances, the Plan Member will be responsible at the time and place of service to pay any Coinsurance directly to the Dental Provider. In other instances, the Plan Member will be billed by the Dental Provider. These arrangements are between the Plan Member and the Dental Provider.

COVERAGE YEAR means when services are covered under this Plan. This means that benefit maximums, Deductibles and Coinsurance limits start and stop during this time. This Dental Plan's Coverage Year is January 1 through December 31.

COVERED EXPENSES are charges for services that are covered under the Plan. Some charges, although eligible, may be subject to Deductible and Coinsurance provisions where applicable and, therefore, are the Plan Member's responsibility to pay. Charges for non-covered expenses are also the Plan Member's responsibility.

COVERED SERVICE means Dental Services described in the Schedule of Coverage section for which Dental Plan benefits will be provided, unless limited or excluded in the Exclusions section of this Dental Plan. A Covered Service is incurred on the date the Dental Service is received.

DEDUCTIBLE means the amount of Covered Expenses payable by the Plan Member each Calendar Year before benefits are paid by the Plan.

DENTAL PROVIDER means professional Dental Providers providing dental services to Plan Members. Each Dental Provider must be licensed, registered or certified by the appropriate state agency where the dental services are performed. Where there is no appropriate state agency, the Dental Provider must be registered or certified by the appropriate professional body. Dental Provider Includes those listed below:

1. **DENTIST** - a Doctor of Dental Surgery (D.D.S.), Oral Pathologist, Oral Surgeon or Doctor of Dental Medicine (D.M.D.).
2. **ORTHODONTIST** – a Dentist who has been specially trained to do orthodontics.
3. **DENTAL HYGIENIST** - a duly licensed Dental Hygienist who works under the supervision of a Dentist.

DENTAL SERVICES means the provision of all dental treatment as defined in the Dental Plan.

DENTALLY NECESSARY means dental care services, supplies or treatment, which are required to treat the Plan Member's condition or Injury. The Plan will determine whether a service or supply is Dentally Necessary based on the review process and generally accepted dental practice. The service or supply must be:

1. Consistent with and appropriate for the treatment or diagnosis of the Plan Member's symptoms, disease, defect or Injury.
2. Of proven value or usefulness, likely to yield additional information, and not redundant when performed with other procedures.
3. The most appropriate and cost-effective level of service or supply which can safely be provided to the Plan Member.

4. Not primarily for the convenience of the Plan Member's family or the Dentist.
5. Appropriate with regard to standards of generally accepted dental practice.

The fact that a Dentist has prescribed, ordered, recommended or approved a treatment, service, or supply does **NOT** in itself make it eligible for payment.

DEPENDENT includes only an Employee's:

1. Spouse (Spouse means an individual as recognized as a spouse for purposes of federal tax laws, including the Code. A Spouse who is legally separated or divorced from the Employee is specifically excluded from the definition of Spouse.); and
2. Unmarried or married children who are less than 26 years of age;
3. Unmarried children age 26 or older who are incapable of self-sustaining employment because of a developmental disability or physical disability and are chiefly dependent upon the Employee for support and maintenance. Proof of such incapacity must be furnished within 31 days of the children reaching the limiting age and annually thereafter.

"Developmental disability" means substantial handicap which results from mental retardation, cerebral palsy, or other neurological disorder.

"Physical disability" means a physical impairment that substantially limits one or more major life activities such as hearing; breathing; mobility (ability to move); learning; or receptive (understanding) and expressive language. Physical disabilities include but are not limited to: blindness/visual impairment; cancer; diabetes; head injury; heart disease; and mobility impairments. An individual with a minor, non-chronic condition of short duration, such as a sprain, broken limb, or the flu, is not considered disabled.

4. Child for whom coverage is required by a Qualified Medical Child Support Order or by an administrative process established under state law.

The term children includes the following:

1. A biological child;
2. An adopted child, including a child placed for adoption. Placement for adoption occurs when an Employee, in anticipation of adopting a child,

assumes and retains legal obligation for the total or partial support of that child. Adoptive placement ceases when or if legal obligation ceases;

3. A stepchild;
4. a child for whom the Employee and/or the Employee's Spouse has been named legal guardian, or
5. A child for whom the Employee is legally financially responsible.
6. A foster child.

At any time, the Plan may require proof that a spouse or child qualifies or continues to qualify as a Dependent as defined by the Plan.

Individuals specifically excluded from the definition of a Dependent are:

1. any person on active military duty;
2. the grandchild of an Employee and/ or the Employee's Spouse;
3. any person covered under this Plan as an Employee; and
4. any person covered as a Dependent by another Employee.

EBSO means EBSO, Inc.

EFFECTIVE DATE means the date on which a person's coverage under this Plan begins.

EMPLOYEE means an Employee of the Employer who is regularly scheduled to actively perform the principle duties of his/her occupation a minimum of 30 hours per week, and who is enrolled and eligible for coverage under the Plan.

Part-time, seasonal, temporary and retired employees are not eligible for coverage under the Plan. Employee does not include the following:

1. a self-employed individual as described in Section 401 (c) of the Code, including, but not limited to, a sole proprietor if the Employer is a sole proprietorship, a person owning more than 2% of the Employer if it is a Subchapter S corporation, a partner of the Employer if it is a partnership, and a member of the Employer if it is a limited liability company and the members are treated as partners for income tax purposes;
2. an employee who is a spouse, child, grandchild, or parent of a person owning more than 2% of the Employer if it is a Subchapter S corporation;

3. any individual included within a unit of employees covered by a collective bargaining unit unless such agreement expressly provides for coverage of the Employee under the Plan;
4. any individual who is a nonresident alien and receives no earned income from the Employer from sources within the United States;
5. any individual who is a leased employee as defined in Section 414(n)(2) of the Code;
6. any individual who performs services for the Employer through, and is paid by, a third-party (including but not limited to an employee leasing or staffing agency) even if such individual is subsequently determined to be a common law employee of the Employer; or
7. any individual who performs services for the Employer pursuant to a contract or agreement (whether verbal or written) which provides that such individual is an independent contractor or consultant, even if such individual is subsequently determined to be a common law employee of the Employer.

EMPLOYER means City of San Luis.

EXPERIMENTAL/INVESTIGATIONAL/INVESTIGATIVE means a drug, device, medical treatment or procedure that meets any of the following:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. The drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or
3. Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

For purposes of this definition, Reliable Evidence means published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

IMMEDIATE FAMILY means the Plan Member's spouse, parent, child, stepchild, foster child, legally adopted child, grandchild, sister, brother, grandparent, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law or son-in-law.

INJURY means a condition caused by accidental means which results in damage to the Plan Member's body from an external force and independently of all other causes and which is **NOT** related to occupation or employment. Chewing accidents are **NOT** considered Injuries.

LIFETIME wherever used in the Plan in reference to benefit maximums and limitations, means while covered under the Plan. Under no circumstances does "**Lifetime**" mean during the lifetime of the Plan Member.

MASTER PLAN DOCUMENT means the Plan Document detailing the provisions of the Plan.

MEDICAID means the medical benefits provided by Title XIX of the Social Security Act, as amended.

MEDICARE means the medical benefits provided by Title XVIII of the Social Security Act, as amended.

PAYMENT PERCENTAGE means the amount payable by the Plan for Covered Expenses after satisfaction of the Deductible amount, if applicable. The Payment Percentage is shown in the Schedule of Coverage.

PHYSICIAN means a legally licensed doctor of medicine and Surgery, doctor of dental medicine or doctor of dental Surgery. A Physician shall not include the Plan Member or any member of his/her Immediate Family.

PLAN means the Plan of benefits offered by the Employer according to the provisions of the Master Plan Document.

PLAN MEMBER means an Employee or Dependent, as defined in the Master Plan Document, who is covered by the Plan.

PLAN YEAR means the twelve month period beginning from the effective date of this Plan. This Plan's Plan Year is July 1st through June 30th. The Plan Year may not be the same as the Coverage Year.

PROTECTED HEALTH INFORMATION (PHI) means health information that is created or received by a Covered Entity, or Employer, and relates to:

1. A person's past, present or future physical or mental health;
2. Provision of health care to that person; or
3. Past, present or future payment for that person's health care.

To be considered Protected Health Information the information must be "individually identifiable health information" which means that in addition to the above requirements, the health information must identify the individual or a reasonable basis must exist to believe that an individual can be identified using the information. Protected Health Information covers information in any form (electronic, oral or written).

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) means a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Plan Member or eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address of the Plan Member and the name and mailing address of each such Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and

4. The name of this Plan.

In addition, a National Medical Support Notice (NMSN) shall be deemed a QMCSO if it:

1. Contains the information set forth below;
 - a. Name of an issuing state agency;
 - b. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Plan Member) or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate recipient(s);
 - c. Identity of an underlying child support order;
2. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated;
3. Informs the Plan Administrator that, if a group health plan has multiple options and the Plan Member is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and
4. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated Dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to Plan Members, except to the extent necessary to meet the requirements of a state law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

SCHEDULE OF COVERAGE means the Schedule at the beginning of the Master Plan Document, or as later amended, which specifies the level of benefits provided by the Plan.

SICKNESS means a disorder of the body, disease, or condition.

SUMMARY HEALTH INFORMATION may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

USUAL, CUSTOMARY AND REASONABLE FEE means a charge for a given service by a provider to the majority of his clients, but such charge must be one which is within the range of fees charged by the majority of providers of similar training and experience, for that service within a specific, limited geographic or socioeconomic area as determined by the Plan. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill or expertise.

The term "area" as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross-section of a level of expenses.

SECTION D

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

EMPLOYEE ELIGIBILITY DATE

For new Employees, coverage becomes available on the first of the month following the date of hire.

Employee absences due to health related factors will be credited toward the eligibility waiting periods. **NOTE:** The Plan will give credit for any waiting periods satisfied in whole or in part under the Employers' previous plan of benefits.

The above requirement regarding length of employment shall be waived in any instance where a Plan Member is merely changing from Dependent status to Employee status, or vice versa. In these instances, coverage shall continue without interruption.

If an Employee loses coverage in this Plan due to Injury, Sickness, layoff, or Employer approved leave of absence and returns to work for the Employer within 3 months of the loss of coverage, he/she will be eligible for coverage on the date of return to work and will **NOT** have to satisfy a new waiting period.

NOTE: If an Employee does not enroll for coverage under this Plan when he/she is initially eligible to enroll for coverage, he/she may enroll for coverage under this Plan at a later date subject to the Special Enrollment Period or the Open Enrollment Period, as explained elsewhere in the Plan Document.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

Coverage becomes effective on the date the eligibility requirement is satisfied, provided the Employee has enrolled for coverage within 30 days from the date he/she first satisfied the eligibility requirements.

DEPENDENT ELIGIBILITY DATE

An Employee becomes eligible for Dependent coverage on the later of:

1. The date the Employee becomes covered;
2. The date the Employee acquires an eligible Dependent; or

3. The date the Employee is required, by a Qualified Medical Child Support Order or by an administrative process established under state law, to provide Dependent coverage.

DEPENDENT EFFECTIVE DATE OF COVERAGE

A Dependent whose coverage is required under a medical support order will be eligible to participate in the Plan as of the date specified in the order, provided the medical support order satisfies the requirements of Arizona law. The Employer will review a medical support order and determine whether it is qualified under Arizona law. Upon request to the Employer, Members may obtain a copy of the procedures governing medical support order determinations, which is available at no charge.

All other Dependent coverage will become effective on the first of the month following one month from the Employee's date of hire. If Dependent status is acquired after the Employee's initial eligibility, the effective date of coverage shall be one month following the month in which the new Dependent becomes eligible for coverage under the Plan, provided the Employee completes a change form and submits it to the Employer within thirty (30) days after the attainment of Dependent status.

Individuals who become an eligible Dependent of an Employee after the Employee's Effective Date of coverage will be eligible for coverage as explained under the CHANGE IN STATUS provision.

NOTE: If an Employee does not enroll his/her eligible Dependents for coverage under this Plan when they are initially eligible to be enrolled for coverage, the Employee may enroll his/her eligible Dependents for coverage under this Plan at a later date subject to the Special Enrollment Period or the Open Enrollment Period, as explained elsewhere in the Plan Document.

CHANGE IN STATUS

If an Employee is covered for single coverage and wants to change to family coverage because of a change in marital status, he/she must request family coverage within 31 days of the date of marriage, in order for coverage to become effective on the date of the marriage.

Should an Employee's marital status change due to divorce or legal separation, notification of that change must be given to the Employer within 60 days of the date of that change.

Employees who have single coverage may request a change to family coverage to add an eligible Dependent child, by submitting a new enrollment form within 31 days of acquiring the child as an eligible Dependent, in which case the child's coverage would become effective on the date he/she became an eligible Dependent of the Employee.

Notwithstanding the foregoing, with respect to an Employee who acquires a new Dependent via birth, adoption, or placement for adoption, coverage for the new Dependent shall begin immediately upon birth, adoption, or placement for adoption and shall not be conditioned upon the enrollment of the new Dependent. However, if an additional premium is charged for the new Dependent and if the new Dependent fails to enroll within the thirty-one (31) day time period referenced above, the coverage shall cease upon expiration of such time period. Even if no additional premium is charged, the Employee should notify the Employer of the birth, adoption, or placement for adoption.

Any request for coverage after the 31 days will be subject to the Special Enrollment Period provision or the Open Enrollment Period.

SPECIAL ENROLLMENT PERIOD

If an Employee declines coverage for himself/herself or for his/her Dependents (including the Employee's spouse) because of other health coverage, the Employee will be able to enroll himself/herself and/or his/her Dependents in this Plan at a future date, provided that the Employee requests coverage within 31 days after other coverage ends. Coverage becomes effective on the first of the month following the date on which the request for enrollment was received by the Employer.

This special enrollment period **ONLY** applies to individuals whose prior Creditable Coverage:

1. Was under COBRA and they exhausted that COBRA coverage; or
2. Was not under COBRA and they lost that prior Creditable Coverage due to:
 - a. events that are similar to COBRA qualifying events (including, but not limited to loss of eligibility as a result of legal separation, divorce, death, termination or reduction in hours of employment or a child aging out under other parent's coverage);
 - b. the plan no longer offering any benefits to a class of similarly situated individuals (e.g. part-time employees);
 - c. the cessation of the employer contributions for that prior Creditable Coverage (actual termination of other coverage is not required);
 - d. moving out of an HMO's service area; or
 - e. reaching a lifetime limit for all benefits.

However, loss of eligibility does **NOT** include a loss due to failure of the individual to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

An Employee must make a request for Special Enrollment within 31 days of the loss of the previous Creditable Coverage and must supply the Plan with proof of loss of coverage under the other group health plan.

Additional Special Enrollment rights exist for Employees and their Dependents (who are eligible but not enrolled for coverage) upon either (1) termination of Medicaid or the State Children's Health Insurance Program (SCHIP) coverage resulting from loss of eligibility; or (2) becoming eligible for premium assistance in this Plan under a Medicaid or SCHIP program. In order to be entitled to this Special Enrollment right, the Employee must request coverage within 60 days of termination or the date the parent or child is determined to be eligible for assistance.

In addition, if an Employee, who declined coverage in this Plan for himself/herself or for his/her Dependents, acquires a new Dependent as a result of marriage, birth, adoption, or placement for adoption, the Employee will be allowed to enroll for coverage for himself/herself and/or his/her spouse and/or the new child, provided that the Employee requests coverage within 31 days after the marriage, birth, adoption or placement for adoption.

EXAMPLES:

1. In the case of marriage, an Employee who had previously declined coverage could become covered, with or without his/her spouse, under the Special Enrollment Period provision. Coverage becomes effective on the date of marriage.
2. In the case of birth or adoption, an Employee and/or his/her spouse, who had previously declined coverage in this Plan could become covered under the Special Enrollment Period provision. Coverage becomes effective on the child's date of birth, adoption or placement for adoption.

NOTE: During a Special Enrollment, the Employee may add a new Dependent under the Employee's current plan option or the Employee may switch to another option, **if applicable** (e.g., an Employee who is covered under this Plan may switch to an HMO plan offered by the Employer or change from one option under this Plan to another option under this Plan).

OPEN ENROLLMENT PERIOD

If an Employee declines coverage for himself/herself or for his/her Dependents (including the Employee's spouse) at the time such individuals are eligible for coverage, the Employee will be able to enroll himself/herself and/or his/her eligible Dependents during any Open Enrollment Period. Each year, during the month of **May**, the Employer will offer an Open Enrollment Period to eligible individuals (Employees and Dependents) who are not already covered under this Plan. Any individual enrolling for coverage under this Plan during an Open Enrollment Period (other than a new Employee who has not yet satisfied his/her eligibility-waiting period) will have coverage effective on the first of July.

NOTE: An Employee's eligible Dependent(s) may **NOT** be covered under this Plan unless the Employee is also covered. (This limitation does not apply to COBRA coverage.)

CHOOSING PLAN OPTIONS

Every year, during the month of May, the Employer will offer an annual enrollment period, during which an Employee who is presently enrolled under one Plan Option may elect to become enrolled in an alternate Plan Option. The effective date of the change in Plan Option will be July 1.

Employees who are presently enrolled under one Plan Option may also elect to become enrolled in an alternate Plan Option if they experience a family status change. A family status change will occur if the Employee gains or loses an eligible Dependent due to divorce, death, loss of eligibility, birth, marriage, adoption or a child reaching the maximum age limit.

Dependents covered by that Employee must be covered under the same Plan Option.

TERMINATION OF INDIVIDUAL COVERAGE

Coverage under this Plan shall terminate at midnight on the earliest of the following:

1. The date the Plan is terminated for all Plan Members;
2. The date a required contribution, if any, is due but the Plan Member fails to make the contribution;
3. With regard to a specific benefit, on the date the benefit is terminated or deleted from the Plan;
4. The date the Plan Member requests termination of any or all coverage under the Plan, subject to IRS Cafeteria rules. The request for termination must be in writing and all forms required by the Plan Administrator must be completed;

5. For Employees: If an Employee does not work the required number of hours to be considered an eligible Employee for any reason other than those specifically listed above, (i.e.; voluntary or involuntary termination of employment; or reduction in hours), coverage will terminate at the end of the month in which the Employee ceases full-time active work;
6. For Dependents:
 - a. Coverage will terminate on the same day as coverage terminates for the Employee under whom they are covered;
 - b. Coverage will terminate at the end of the month in which the individual no longer meets the Plan's Definition of an eligible Dependent;
 - c. For Dependents whose coverage became effective upon their birth, adoption, or placement for adoption under Change in Status, coverage will terminate on the date thirty-one (31) days from the effective date of coverage if an additional premium is charged for the new Dependent and the new Dependent fails to enroll with-in thirty-one (31) days following the birth, adoption, or placement for adoption.
 - d. Coverage will terminate on the date as specified in the Qualified Medical Child Support Order or by an administrative process established under state law if eligibility for Dependent coverage is solely based on this order.

NOTE: Coverage shall be canceled automatically, without notice, if a Plan Member:

1. Attempts, through deceit, to obtain benefits that otherwise would not be provided by this Plan; or
2. Attempts to obtain benefits for someone not entitled to benefits under this Plan.

Rescission. Coverage under this Plan may be Rescinded under certain circumstances. A determination by the Plan that a Rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Plan Member whose coverage is being Rescinded will be provided a 30 day notice period as described under Health Care Reform and regulatory guidance. Such notice shall be considered an Adverse Benefit Determination. At the conclusion of the 30 day notice

period, coverage shall be terminated retroactive to the date identified in the notification. Claims incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims.

This Plan shall at all times be in compliance with the applicable state family medical leave act and/or the Family and Medical Leave Act (FMLA) of 1993, or as later amended, provided the Employer is required to comply with such acts. The FMLA will run concurrently with any extension of coverage specified above.

SECTION E

CONTINUATION OF COVERAGE UPON INDIVIDUAL TERMINATION (COBRA)

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan ("Plan") offer Employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform Plan Members and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. The following paragraphs generally explain COBRA coverage, when it may become available and what a Qualified Beneficiary needs to do to protect his or her right to receive it.

We use the pronoun "you" in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a Qualified Beneficiary.

WHAT IS COBRA CONTINUATION COVERAGE? COBRA coverage is a temporary extension of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event". Specific Qualifying Events are listed below in the section entitled "What is a Qualifying Event".

The Plan has the following components, Dental, and you may be enrolled in one or more of these components. COBRA (and the description of COBRA coverage contained in the plan document and summary plan description "SPD") applies only to the group health plan benefits offered under the Plan (the Dental) and not to any other benefits offered by the Employer (such as life insurance, disability income, or accidental death or dismemberment benefits).

COBRA coverage is the same coverage that the Plan gives to other Plan Members under the Plan who are not receiving COBRA coverage. Each Qualified Beneficiary who elects COBRA will have the same rights under the Plan as other Plan Members covered under the component or components of the Plan elected by the Qualified Beneficiary, including Open Enrollment and Special Enrollment rights.

If an Employer offers more than one level of benefits and also offers an Open Enrollment Period (during which time, Plan Members are allowed to change to a different level of benefits or to add additional coverage, such as dental or vision), Qualified Beneficiaries must also be allowed to make these selections during an Open Enrollment Period.

In considering whether or not to take COBRA, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. You will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not obtain continuation coverage for the maximum time available to you. You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the Qualifying Event. You will also have the same special enrollment right at the end of continuation coverage if you obtained continuation coverage for the maximum time available to you.

WHO IS A QUALIFIED BENEFICIARY? In general, a Qualified Beneficiary is:

1. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the spouse of a covered Employee, or a Dependent child of a covered Employee.
2. A child born to, adopted by, or placed for adoption with a covered Employee during a period of COBRA coverage is considered to be a Qualified Beneficiary provided that, if the covered Employee is a Qualified Beneficiary, the covered Employee has elected COBRA coverage for himself/herself. The child's COBRA coverage begins when the child is enrolled in the Plan, including when enrolled through a Special Enrollment or an Open Enrollment.
3. A child who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO), received by the Employer during the covered Employee's period of employment with the Employer, is entitled to the same rights to elect COBRA as an eligible Dependent child of the covered Employee.

If however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer coverage constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes not only common-law Employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his/her performance of services for the Employer sponsoring the Plan (e.g., self-employed individuals, independent contractors, owners or corporate directors).

WHAT IS A QUALIFYING EVENT? If you are a covered **Employee** you will be entitled

to elect COBRA if you lose your group health coverage under the Plan because of either of the following Qualifying Events:

1. your hours of employment are reduced; or
2. your employment ends for any reason other than your gross misconduct.

If you are a covered **spouse** of an Employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because of any of the following Qualifying Events:

1. your spouse dies;
2. your spouse's hours of employment are reduced;
3. your spouse's employment ends for any reason other than his/her gross misconduct;
4. your spouse becomes entitled to Medicare; or
5. you become divorced or legally separated from your spouse. Also, if your spouse (the Employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event for you even though your coverage was reduced or eliminated before the divorce or legal separation.

If you are a covered **Dependent child** of an Employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because of any of the following Qualifying Events:

1. the Employee dies;
2. the Employee's hours of employment are reduced;
3. the Employee's employment ends for any reason other than his/her gross misconduct;
4. the Employee becomes entitled to Medicare;
5. the parents of the Dependent child become divorced or legally separated; or
6. you stop being eligible for coverage under the Plan as a Dependent child.

If an Employee takes FMLA leave and does not return to work at the end of the leave, the Employee (and the Employee's spouse and Dependent children, if any) will be

entitled to elect COBRA if:

1. they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and
2. they will lose Plan coverage within 18 months because of the Employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave.)

If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the Employee and Dependents will be entitled to COBRA coverage even if they failed to pay the Employee portion of the contribution for coverage under the Plan during the FMLA leave.

WHEN IS COBRA COVERAGE AVAILABLE? When the Qualifying Event is the end of employment, reduction of hours of employment, or death of the Employee, the Plan will offer COBRA coverage to Qualified Beneficiaries. You need not notify the Employer of any of these three Qualifying Events. An Election Form will automatically be provided.

For the other Qualifying Events (divorce or legal separation of the Employee and spouse, or a Dependent child losing eligibility for coverage as a Dependent child), a COBRA Election Form will be sent to you only if you notify the Employer in writing within 60 days after the date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the Qualifying Event.

WHAT IS THE ELECTION PERIOD AND HOW LONG MUST IT LAST? An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Employer's Plan. A Plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of his/her right to elect COBRA continuation coverage.

HOW MAY COBRA COVERAGE BE ELECTED? To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA election notice and submit it to the COBRA Administrator.

Mail, hand-deliver or fax the completed Election Form to:
COBRA/Eligibility Department

EBSO, Inc.
2145 Ford Parkway, Suite 200
St. Paul, Minnesota 55116-1912
(651) 695-2500 or 1-800-486-7664
Fax number (651)695-1648

The Election Form must be completed in writing and mailed, hand-delivered, or faxed to the individual at the address/fax number specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; electronic communications, including e-mail messages; and faxed communications (unless they are on a proper Election Form).

If mailed, your Election Form must be postmarked (and if hand-delivered or faxed, your Election Form must be received by the individual at the address/fax number specified above) no later than 60 days after the date of the COBRA election notice provided to you at the time of your Qualifying Event. **IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.**

Each Qualified Beneficiary (including a child who is born to, adopted by or placed for adoption with a COBRA covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage. Covered Employees and spouses (if the spouse is a Qualified Beneficiary) may elect COBRA on behalf of all of the Qualified Beneficiaries, and parents may elect COBRA on behalf of their children.

Qualified Beneficiaries may be enrolled in one or more group health components of the Plan at the time of a Qualifying Event. If a Qualified Beneficiary is entitled to a COBRA election as the result of a Qualifying Event, he/she, may elect COBRA under any or all of the group health components of the Plan under which he/she was covered on the day before the Qualifying Event.

When you complete the Election Form you must notify the Employer if any Qualified Beneficiary has become enrolled under Medicare (Part A, Part B, or both) and, if so, the date of Medicare enrollment. If you become enrolled under Medicare (or first learn that you are enrolled under Medicare) after submitting the Election Form, immediately notify the Employer of the date of your Medicare enrollment at the address specified for delivery of the Election Form.

Qualified Beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are enrolled under Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he/she becomes enrolled under Medicare benefits or becomes covered under

other group health plan coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied). See the section entitled “When may a Qualified Beneficiary’s COBRA continuation coverage be terminated?”.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the COBRA Administrator.

If you reject COBRA before the due date, you may change your mind as long as you furnish a completed Election Form before the due date.

WHAT ARE THE MAXIMUM COVERAGE PERIODS FOR COBRA CONTINUATION COVERAGE? The maximum coverage periods are based on the type of Qualifying Event and the status of the Qualified Beneficiary, as shown below:

1. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
2. In the case of a covered Employee’s enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
 - a. 36 months after the date the covered Employee becomes enrolled in the Medicare program. For example, if a covered Employee becomes enrolled under Medicare eight months before the date on which his employment terminates, COBRA coverage under the Plan for his spouse and Dependent children who lost coverage as a result of his termination can last up to 36 months after the date the Employee became enrolled under Medicare, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months). This COBRA coverage period is available only if the covered Employee becomes enrolled under Medicare within 18 months **BEFORE** the termination or reduction of hours; or
 - b. 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee’s termination of employment or reduction of hours of employment.
3. In the case of any other Qualifying Event than those described above, the

maximum coverage period ends 36 months after the Qualifying Event.

4. In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retired Employee ends on the date of the covered retired Employee's death. The maximum coverage period for a Qualified Beneficiary who is the surviving spouse or Dependent child of the covered retired Employee ends on the earlier of the date of the Qualified Beneficiary's death or the date that is 36 months after the death of the covered retired Employee.

In the case of a Qualified Beneficiary who is a child born to, adopted by or placed for adoption with a COBRA covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born, adopted or placed for adoption.

UNDER WHAT CIRCUMSTANCE CAN THE MAXIMUM COVERAGE PERIOD BE EXPANDED? If the Qualifying Event that resulted in your COBRA election was the covered Employee's termination of employment or reduction in hours, an extension of the maximum coverage period may be available if a Qualified Beneficiary is disabled or a second Qualifying Event occurs. You must notify the Employer of a disability or a second qualifying event in order to extend the period of COBRA coverage. **FAILURE TO PROVIDE NOTICE OF A DISABILITY OR SECOND QUALIFYING EVENT WILL ELIMINATE THE RIGHT TO EXTEND THE PERIOD OF COBRA COVERAGE.**

1. **Disability extension of COBRA coverage.** If a Qualified Beneficiary is determined by the Social Security Administration to be disabled and you notify the Employer in a timely fashion, all of the Qualified Beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for Qualified Beneficiaries who are receiving COBRA coverage because of a Qualifying Event that was the covered Employee's termination of employment or reduction in hours. The disability must have started at some time before the 61st day after the covered Employee's termination of employment or reduction of hours (this includes disabilities that began prior to the Employee's termination of employment or reduction of hours). The disability must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each Qualified Beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if you notify the Employer in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- a. the date of the Social Security Administration's disability

determination;

- b. the date of the covered Employee's termination of employment or reduction of hours; or
- c. the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered Employee's termination of employment or reduction of hours.

You must provide the Social Security Administration's determination notice within 18 months after the covered Employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

2. **Second Qualifying Event extension of COBRA coverage.** An extension of coverage will be available to spouses and Dependent children who are receiving COBRA coverage if a Second Qualifying Event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered Employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a Second Qualifying Event occurs is 36 months. Such Second Qualifying Events may include the death of a covered Employee, divorce or legal separation from the covered Employee, or a Dependent child's ceasing to be eligible for coverage as a Dependent under the Plan. These events can be a Second Qualifying Event only if they would have caused the Qualified Beneficiary to lose coverage under the Plan if the first Qualifying Event had not occurred. (This extension is not available under the Plan when a covered Employee becomes enrolled under Medicare.)

This extension due to a Second Qualifying Event is available only if you notify the Employer in writing of the Second Qualifying Event within 60 days after the later of:

- a. the date of the Second Qualifying Event; or
- b. the date on which the Qualified Beneficiary would lose coverage under the terms of the Plan as a result of the Second Qualifying Event (if it had occurred while the Qualified Beneficiary was still covered under the Plan).

WHAT IS THE COST OF COBRA CONTINUATION COVERAGE? The amount a Qualified Beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the group health Plan for coverage of a similarly situated Plan Member who is not receiving COBRA coverage (including both Employer and Employee contributions). The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA

premium changes.

WHAT ARE THE COBRA CONTINUATION COVERAGE PAYMENT PROCEDURES?

If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage no later than 45 days after the date of your election. (This is the date your Election Form is postmarked, if mailed, or the date your Election Form is received by the individual at the designated address/fax number, if hand-delivered or faxed.) See the section above entitled “How may COBRA coverage be elected?”

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make the first payment. (For example, your employment terminates on September 30, and you lose coverage on September 30. You elect COBRA coverage on November 15. Your initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of your COBRA election.) You are responsible for making sure that the amount of your first premium payment is correct. You may contact the Employer using the contact information provided under the section entitled “How may COBRA coverage be elected?” to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, YOU WILL LOSE ALL COBRA RIGHTS UNDER THE PLAN.

After you make your first payment for COBRA coverage you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each Qualified Beneficiary will be disclosed in the election notice provided to you at the time of your Qualifying Event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. Following your election of COBRA coverage, you will receive a packet of 12 coupons to submit with your monthly COBRA premium. Periodic notices of payments due for these coverage periods will not be sent (that is, a monthly bill will not be sent to you for your COBRA coverage – it is your responsibility to pay your COBRA premiums on time).

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that

payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, YOU WILL LOSE ALL RIGHTS TO COBRA COVERAGE UNDER THE PLAN.

All COBRA premiums must be paid by check or money order. CASH WILL NOT BE ACCEPTED.

Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to:

COBRA/Eligibility Department
EBSO, Inc.
2145 Ford Parkway, Suite 200
St. Paul, Minnesota 55116-1912
(651) 695-2500 or 1-800-486-7664
Fax number (651)695-1648

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand-delivering a check if your check is returned due to insufficient funds or otherwise.

WHEN MAY A QUALIFIED BENEFICIARY'S COBRA CONTINUATION COVERAGE BE TERMINATED? COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can terminate before the end of the maximum coverage period for several reasons, which are described below.

COBRA coverage will automatically terminate before the end of the maximum coverage period if:

1. timely payment is not made to the Plan with respect to the Qualified Beneficiary. **NOTE:** Invalid payments (i.e., checks returned due to insufficient funds) will result in retroactive termination of coverage.
2. the Employer ceases to provide any group health plan (including successor plans) to any Employee.

3. a Qualified Beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the Qualified Beneficiary have been exhausted or satisfied).
4. a Qualified Beneficiary first becomes enrolled under Medicare benefits (Part A, Part B, or both) after electing COBRA.
5. during a disability extension period, the disabled Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled.

You must notify the Employer in writing within 30 days if, after electing COBRA, a Qualified Beneficiary becomes enrolled under Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the Qualified Beneficiary have been exhausted or satisfied). COBRA coverage will terminate (retroactively, if applicable) as of the date of Medicare enrollment or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any pre-existing condition exclusions for a pre-existing condition of the Qualified Beneficiary). The Employer will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare enrollment or other group health plan coverage.

If a disabled Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Employer of that fact within 30 days after the Social Security Administration's determination. If the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all Qualified Beneficiaries will terminate (retroactively, if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled. The Employer will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice that the disabled Qualified Beneficiary is no longer disabled. (For more information about the disability extension period, see the section above entitled "Under what circumstances can the maximum coverage period be expanded?")

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a Plan Member not receiving COBRA coverage (such as fraud).

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

DOES A QUALIFIED BENEFICIARY HAVE A DUTY TO KEEP THE PLAN INFORMED OF ADDRESS CHANGES?

In order to protect your family's rights, you must keep the Employer and the Plan's Claims Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Employer and the Plan's Claims Administrator.

QUESTIONS? If you have questions about your COBRA continuation coverage, you should contact the Employer or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

CONTACTS: You may obtain information about COBRA coverage on request from:

1. **The Employer (Plan Administrator):**

City of San Luis
1090 E. Union Street
San Luis, AZ 85349
928-341-8547

2. **COBRA Administrator:**

COBRA/Eligibility Department
EBSO, Inc.
2145 Ford Parkway, Suite 200
St. Paul, Minnesota 55116-1912
(651) 695-2500 or 1-800-486-7664
Fax number (651)695-1648

The contact information for the Plan may change from time to time. The information will be included in the Plan's most recent SPD (if you are not sure whether this is the Plan's most recent SPD, you may request the most recent one from the Employer).

YOU MUST GIVE NOTICE OF CERTAIN QUALIFYING EVENTS

If you or your Dependent(s) experience any of the following qualifying events, you or your Dependent(s) must notify the Plan Administrator/COBRA Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would end as a result of the qualifying event:

- your divorce or legal separation.
- your child no longer qualifies as a Dependent under the Plan.
- the occurrence of a secondary qualifying event as described in "Second Qualifying Event extension of COBRA coverage" (this notice must be received prior to the end of the initial 18-month or 29-month COBRA period). See "Disability extension of COBRA coverage" for additional notice requirements.

Notice must be made in writing and must include: the name of the Plan; name and address of the Employee covered under the Plan; name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g. divorce decree, birth certificate, disability determination, etc.).

SECTION F

UNIFORMED SERVICES CONTINUATION AND REINSTATEMENT PROVISION

Continuation

A Plan Member who:

1. Is employed by the Employer;
2. Is determined by the Employer to be eligible for benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA);
3. Is absent from his/her position of employment with the Employer by reason of service in the uniformed services; and

4. Would otherwise have his/her coverage under the Plan terminated,

may elect to continue the coverage under the Plan that the Plan Member and his/her eligible covered Dependents had prior to such absence for a period not to exceed the lesser of:

1. The twenty four month period beginning on the date on which the Plan Member's absence begins; or
2. The day after the date on which the Plan Member fails to apply for or return to a position of employment as specified by the Employer.

Reinstatement

Upon re-employment, coverage under the Plan will be reinstated for a person who was absent from his/her position of employment with the Employer by reason of service in the uniformed services, as well as for his/her eligible Dependents who were covered Plan Members under the Plan at the time the absence began provided that:

1. The person was a covered Plan Member under the Plan until the time his/her absence from employment with the Employer commenced by reason of service in the uniformed services;
2. The person makes application for re-employment within the time limit specified by the Employer; and

3. At the time the person makes application for re-employment, he/she is entitled to benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

In such instances, an exclusion of the Plan, Pre-existing Condition Limitation, or waiting period will not be applied, if that exclusion of the Plan, Pre-existing Condition Limitation, or waiting period would not have been applied had coverage not been terminated as a result of service in the uniformed services. This also applies to any eligible Dependent of the covered person who becomes covered by the Plan as a result of such reinstatement of coverage.

An exclusion or waiting period may be imposed for any Injury or Sickness determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of service in the uniformed services.

SECTION G

GENERAL LIMITATIONS AND EXCLUSIONS

Notwithstanding any provision in the Plan to the contrary, the Plan will not provide benefits for the following services, dental procedures or supplies, regardless of Dental Necessity or recommendation by a Dental Provider. The Plan Member is responsible for 100% of the expenses associated with the listed exclusions. These expenses are not Covered Services and, therefore, will not count toward the Annual Out-of-Pocket Maximum.

1. Charges for any device ordered while the Plan Member was covered under this Dental Plan and not delivered or installed within thirty (30) days after termination of coverage.
2. Replacement of duplicate, lost missing or stolen appliances or prosthetic devices.
3. Charges for all services, supplies and treatment related to dental implants.
4. Any procedure not listed as a Covered Service.
5. Any procedure that began before the date the Plan Member's dental coverage started to include a service which is:
 - a. An appliance, or modification of an appliance, for which an impression was made before such person became covered under the Dental Plan;
 - b. A crown, bridge or gold restoration, for which a tooth was prepared before such person became covered under the Dental Plan;
 - c. Root canal therapy, for which the pulp chamber was opened before such person became covered under the Dental Plan.

X-rays and prophylaxis shall not be deemed to start a dental procedure.

6. Services, supplies or treatment that is cosmetic in nature, including charges for personalization or characterization of dentures. Veneers or porcelains posterior to the second bicuspid are considered optional, and as such, are not Covered Services.
7. Surgical services with respect to congenital or developmental malformations. These conditions include: cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis, and anodontia.

8. Appliances, restoration or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting or replacing tooth structure lost as a result of abrasion or attrition, except as provided under Orthodontic Services.
9. Charges for services, supplies or treatment for which benefits are payable under any employer sponsored group medical or dental plan.
10. A service not furnished by a Dentist, except;
 - a. That performed by a licensed dental hygienist under a Dentist's supervision;
 - b. X-rays ordered by a Dentist; and
 - c. Denturist.
11. Charges for over-dentures, including related root canal therapy and supportive restorations.
12. Replacement of a prosthetic which in the Dentist's opinion can be repaired or does not need replacement.
13. Fixed prosthetics and/or partials for Plan Members through the age of fifteen. An allowance will be made for a temporary acrylic partial.
14. A posterior fixed prosthetic appliance when done in connection with a removable appliance in the same arch.
15. Charges in excess of the least costly plan of treatment when there is more than one accepted method of treatment for a dental condition.
16. Charges resulting from changing from one Dentist to another while receiving treatment, or from receiving care from more than one Dentist for one dental procedure, to the extent the total charges billed exceed the amount that would have been billed if one Dentist had performed all the required Dental Services.
17. Porcelain, gold, porcelain veneer, acrylic veneer, and precious metal crowns over primary teeth for Plan Members through the age of fifteen (15). An allowance will be made for an acrylic crown.
18. Charges for precision attachments, semi-precision attachments, instruction in dental plaque control, dental hygienics, or nutritional counseling.
19. Charges for services or supplies related to diagnosis of, or treatment of temporomandibular joint syndrome, by whatever name called.

20. Expenses for completion of claim forms or for preparation of medical reports; for missed appointments or for telephone consultations.
21. Charges Incurred for treatment of an Injury or Sickness sustained while the Plan Member is participating in an illegal occupation; commission of, or an attempt to commit, a felony; or voluntary participation in a riot, insurrection or civil disobedience.
22. Charges in excess of any maximum benefit stated in the Plan.
23. For expenses made which are in excess of the Usual, Customary and Reasonable Fee.
24. Expenses Incurred by a Plan Member that may be covered or reimbursed by any public program, or by any national, state, provincial, county, or local government or any other political subdivision, instrumentality or agency thereof, except Medicare and Medicaid.
25. Services furnished to the Plan Member in any veteran's Hospital, military Hospital, institution or facility operated by the United States Government, by any state government, by any agency or instrumentality of such government, or any foreign government agency, for which the Plan Member has no legal obligation to pay for services rendered or expenses Incurred, except for care or service furnished by a tax supported state Hospital for treatment of Mental/Nervous Disorders.
26. Services performed by a person who is a member of the Plan Member's Immediate Family or who resides in the Plan Member's home.
27. Expenses for which the Plan Member has no legal obligation to pay or for an expense which would not have been made if the person did not have coverage under this Plan.
28. Charges for taxes or surcharges, other than those which a medical facility is legally required to make.
29. Charges for Out-of-Network services, except for United States providers.

SECTION H

DENTAL BENEFITS

NOTE: The only Out-of-Network providers covered under this Plan are United States providers. All other Out-of-Network providers are NOT covered.

Covered Dental Expenses

The Plan will pay benefits for Covered Expenses Incurred by a Plan Member for dental services, only when performed by a Dentist or a Dental Hygienist, or other dental provider working under the direction and supervision of the Dentist. The payment is subject to the General Limitations and Exclusions and all other provisions of the Plan. The Payment Percentages and maximums are shown in the Schedule of Coverage.

Class I Services –Preventive and Diagnostic Services

1. Teeth cleaning
2. Exams
3. Dental x-rays
4. Fluoride treatments
5. Sealants

Class II Services – Basic Services

1. Fillings (amalgam and anterior, posterior composite (white) fillings)
2. Simple extractions
3. Non-surgical periodontics
4. Endodontics (root canal therapy)

Class III Services – Major Dental Repair Services

1. Restorative crowns
2. Restorative onlays
3. Bridges
4. Dentures
5. Partial dentures

Class IV Services – Orthodontic Services.

NOTE: Dependent children must be covered under the Dental Plan for twelve (12) consecutive months before orthodontia benefits are available.

1. Active appliances. Allowance includes diagnostic services, the treatment plan, the fitting, making and placing of the active appliance, and all related office visits including post-treatment stabilization.

2. Surgical reposition of the jaw, facial bones and/or teeth to correct malocclusion and x-rays.
3. Any other Class I, II or III services that are performed in connection with orthodontic treatment shall be payable under their appropriate payment percentage and not included under the orthodontic limitations and/or payment percentages.

SECTION I

CARE PROVIDED BY THE UNITED STATES GOVERNMENT

The Plan will reimburse for care rendered by the Veterans Administration for non-service connected disabilities, on the same basis as these services are otherwise covered by the Plan.

The Plan will reimburse for care rendered by the United States to military retirees and dependents who are covered by this Plan on an inpatient basis through a facility of the uniformed services, on the same basis as these services are otherwise covered under the Plan.

COORDINATION OF BENEFITS

The Plan contains a non-profit provision coordinating it with other Plans under which an individual is covered so that total benefits available will not exceed 100% of the Allowable Expense for the services. When this Plan pays second, it will pay, with respect to each claim submitted for payment, 100% of Allowable Expenses less whatever payments were actually made by the Plan (or Plans) that paid first. In addition, when this Plan pays second, it will never pay more in benefits than it would have paid during the Plan Year for each claim as it is submitted had it been the Plan that paid first.

An "Allowable Expense" means any health care service or expense, including coinsurance, copays or copayment and without reduction for any deductible, that is covered in full or in part by any of the Plan covering the person. Allowable Expenses do not include expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under this Plan.

"Claim Determination Period" means the time during any one benefit year when a person is covered and incurs charges for services or supplies covered under this Plan and one other plan.

As each claim is submitted, each plan determines its liability and pays or provides benefits based upon Allowable Expenses incurred during the Claim Determination Period. However, that determination is subject to adjustment as later Allowable Expenses are incurred during the same Claim Determination Period.

"Plan" means any plan providing health benefits or health services including but not limited to:

1. Group, blanket or franchise insurance coverage;
2. Group practices and other group pre-payment coverage;
3. Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans; and
4. Any coverage under governmental programs, such as Medicare, Tricare/CHAMPUS, and any coverage required or provided by any statute, such as no-fault auto insurance.

"Plan" shall not include:

1. School accident type coverage;
2. Hospital indemnity coverage; or
3. Individual insurance coverage.

EFFECT ON BENEFITS

Plans determine the sequence in which they pay benefits, or which plan pays first, by applying uniform order of benefit determination rules in a specific sequence. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC). Any Plan that does not use these same rules always pays its benefit first.

When two Plans cover the same person, the following order of benefit determination rules establish which Plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until the order of benefits is established. The rules are as follows:

Rule 1: Non-Dependent/Dependent

- A. The Plan that covers a person as an employee, retiree, member or subscriber (that is, other than as a dependent) pays first; and the Plan that covers the same person as a dependent pays second;
- B. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is:

1. secondary to the Plan covering the person as a dependent; and
2. primary to the Plan covering the person as other than a dependent (that is, the Plan covering the person as a retired employee);

then the order of benefits is reversed, so that the Plan covering the person as a dependent pays first; and the Plan covering the person other than as a dependent (that is, as a retired employee) pays second.

Rule 2: Dependent Child Covered Under More Than One Plan.

- A. The Plan that covers the parent whose birthday falls earlier in the calendar year pays first; and the Plan that covers the parent whose birthday falls later in the calendar year pays second, if:
 1. the parents are married or living together;
 2. the parents are not separated (whether or not they ever have been married); or
 3. a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.
- B. If both parents have the same birthday, the Plan that has covered one of the parents for a longer period of time pays first; and the Plan that covered the other parent for the shorter period of time pays second.
- C. The word “birthday” refers only to the month and day in a calendar year, not the year in which the person was born.
- D. If the specific terms of a court decree state that one parent is responsible for the child’s health care expenses or health care coverage, and the Plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child’s health care services or expenses, but that parent’s spouse does, the Plan of the spouse of the parent with financial responsibility pays first. This rule applies to plan years commencing after the Plan is given notice of the court decree.
- E. If the parents are divorced, separated or not living together (whether or not they have ever been married), and there is no court decree allocating responsibility for the child’s health care services or expenses, the order of benefit determination among the Plans of the parents and their spouses (if any) is:
 1. The Plan of the custodial parent pays first;

2. The Plan of the spouse of the custodial parent pays second; and
3. The Plan of the non-custodial parents pays third; and
4. The Plan of the spouse of the non-custodial parent pays last.

If the dependent child is covered under a Plan of an individual other than the parents, the order of benefits is determined as if those individuals were the parents of the child. The custody rule is applicable to anyone who has legal custody of the dependent child.

Rule 3: Active/Laid-off or Retired Employee

- A. The Plan that covers a person as an active employee, that is, an employee who is neither laid-off or retired, is primary. The Plan covering that same person as a retired or laid-off employee is secondary. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee.
- B. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- C. This rule does not apply if Rule #1 described above can be used to determine the order of benefits

This rule is applicable only in the rare situations when the same individual is covered under two plans, one as an active employee and the other as a retired or laid-off employee. This rule does not apply to an individual covered under his or her own Plan as either an active, retired, or laid-off employee and also as a dependent under another Plan. In those situations, Rule #1 should be applied.

Rule 4: Continuation Coverage

- A. If a person whose coverage is provided under a right of continuation under federal or state law (e.g. COBRA) is also covered under another Plan, the Plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the Plan providing continuation coverage to that same person pays second.
- B. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

This rule is applicable only to the rare situations when an individual is covered under both COBRA and non-COBRA plans as other than a dependent, or as a dependent of an

individual who is covered under both plans as a non-dependent. In the majority of continuation coverage situations, two employee spouses are involved (one on COBRA and one on the basis as active employment). In this scenario, Rule #1 is applicable.

Rule 5: Longer/Shorter Length of Coverage

If none of the four previous rules determines the order of benefits, the Plan that covered the person for the longer period of time pays first; and the Plan that covered the person for the shorter period of time pays second.

Rule 6: None of the Above Rules Apply

If the preceding rules do not apply, the allowable expenses shall be shared equally between the Plans.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any other plan, the plan may without the consent of or notice to any persons release to, or obtain from, any insurance company or other organization or person any information with respect to any person which it deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan information as may be necessary to implement this provision.

FACILITY OF PAYMENT

Whenever payments which should have been made under the Plan in accordance with this provision have been made under any other plan, the Plan shall have the right, exercisable alone and at its sole discretion, to pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision and amounts so paid shall be deemed to be benefits paid under this Plan and to the extent of such payments for covered services, the Plan shall be fully discharged from liability.

SECTION J

MEDICARE SELECTION PROVISION

If the Employer has **less** than 20 Employees in the current Calendar Year, Medicare coverage is primary (and this Plan will be secondary) for active Employees age 65 or older and their Dependents 65 or older. This Plan will reduce payment by the amount paid or payable by Medicare.

If the Employer had 20 or **more** Employees in the current or preceding Calendar Year, Federal law requires that Medicare coverage be secondary to this Plan. The Plan Member has the option of rejecting this Plan thereby retaining Medicare as his/her primary coverage. If the Plan Member chooses Medicare as primary, the Employer cannot provide any supplemental coverage. If the Plan Member rejects coverage under this Plan that choice must be made in writing to the Employer.

Federal law also mandates which plan is primary in the case of certain persons who are totally disabled or have end stage renal disease.

NOTE: This Plan will determine the primary and secondary payment of claims based on the current rules and regulations set forth by Medicare.

SECTION K

GENERAL PROVISIONS

The Plan and The Master Plan Document

The Plan Sponsor has filed the Master Plan Document in the office of the Human Resource Department, which can be inspected at any time during normal working hours by any Plan Member.

The Plan is a legal entity. Legal notices may be filed with, and legal process served upon, the Plan Administrator.

Plan Administrator

The Plan Administrator as used herein shall be the person or firm responsible for the day to day functions and management of the Plan. The Plan Administrator is the Employer.

The construction and interpretation of the Plan are vested with the Plan Administrator, in its absolute discretion, including, without limitation, the determination of benefits, eligibility and interpretation of Plan provisions. The Plan Administrator will endeavor to act, whether by general rules or by particular decisions, so as to treat all persons in similar circumstances without discrimination. All such decisions, determinations and interpretations shall be final, conclusive and binding upon all parties having an interest in the Plan.

Named Fiduciary

The Named Fiduciary is the Plan Administrator and has the authority to control and manage the operation and administration of the program. A participant under the Plan will not receive Plan benefits unless the Plan Administrator determines that the participant is entitled to such benefits.

Claims Administrator

The Claims Administrator will provide technical services in connection with operation of the coverage and performing other functions.

The Plan Is Not A Contract

The Plan shall not be deemed to constitute a contract between the Employer and any Employee or be a consideration for, or an inducement or condition of, the employment of an Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provision of any collective bargaining agreements which may be made by the Employer with the bargaining representative of any Employees.

Exchange Of Information

The Plan will promptly provide to appropriate Federal, state and local law enforcement authorities and to other appropriate health plans:

1. Information indicating a potential violation of civil, criminal, or administrative laws relating to fraud and abuse with respect to health plans.
2. Information requested by Federal, state, or local law enforcement agencies which the agency states is relevant to an investigation, audit, evaluation, or inspection under the Federal Fraud and Abuse Control Program.
3. Information which would assist in the identification of potential violations or assist in the identification of areas requiring investigation, audit, evaluation, or inspection. Such information may include:
 - a. Surveys; Quality assurance reviews;
 - b. Provider and patient profiles;
 - c. Utilization review, and
 - d. Other similar analyses.

Alternative Treatment

The Plan Administrator has the right to approve coverage for treatment, procedures or facilities that are not normally covered under the Plan, if the Plan Administrator feels that this alternative treatment, procedure or facility offers a cost-effective method of treating the Plan Member's condition. Such approval in no way obligates the Plan Administrator to approve such coverage in the future, nor does it obligate the Plan

Administrator to approve of Alternative Treatment for any other Plan Member. Each case will be decided on its own merits.

Free Choice of Physician

Each Plan Member has a free choice of any Physician/**Dentist** or surgeon, and the Physician/**Dentist**-patient relationship shall be maintained. The Plan Member, together with his Physician/**Dentist**, is ultimately responsible for determining the appropriate course of **dental** treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

The PPO providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any PPO provider.

Qualified Medical Child Support Orders (QMCSO)

The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a “Qualified Medical Child Support Order” (“QMCSO”) if such an individual is not already covered by the Plan as an eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

“Alternate Recipient” shall mean any child of a Plan Member who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Plan Member’s eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Plan Member.

Upon receiving a Medical Child Support Order (Order), the Plan Administrator shall, as soon as administratively possible:

1. Notify the Plan Member and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan’s procedures for determining whether the Order qualifies as a QMCSO; and
2. Make an administrative determination if the Order is a QMCSO and notify the Plan Member and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice (Notice), the Plan Administrator shall:

1. Notify the state agency issuing the Notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
 - a. Whether the child is covered under the Plan; and
 - b. Either the Effective Date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator shall:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and
2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

A Plan Member may request at any time a copy of QMCSO procedures from the Plan without charge.

Other Service Plan Contracts

If any Plan Member is covered under more than one Plan, the coverage that would be provided under this Plan in the absence of this provision shall be reduced to the extent necessary so that the sum of such reduced coverage, together with the benefits, if any, that are paid or payable under such other Plan contract for health service shall not exceed the total charges for the health service.

Worker's Compensation Notice

The Plan is not in lieu of, is not in any way subject to, and does not affect any requirement for coverage by worker's compensation insurance.

Erroneous Payment Refund Provision

Covered Expenses are occasionally paid erroneously by the Plan (i.e., paid more than once; incorrectly paid under the Plan's terms, conditions, limitations or exclusions; or conditionally paid pending further review). An Employee, Dependent, or health care service provider receiving such an overpayment or erroneous payment shall, upon discovery or notice thereof, return such payment to the Plan within 30 days of discovery or demand. Neither the Plan nor the Plan Administrator shall have any obligation to make any other payment of the bill prior to refund by the health care provider, Employee or Dependent. A health care provider may not apply an erroneous or duplicate payment to another bill balance or any other Dependent. The Plan Administrator shall have the exclusive right to choose who will repay it for an overpayment or erroneous payment (i.e., including but not limited to the Employee, Dependent, health care service provider or another health benefit plan). If the Plan elects to seek refund from the Employee or Dependent, recovery of the overpaid amount shall, at the Plan Administrator's option, be reimbursed in a lump-sum, time payments or deducted from future claims presented for processing.

Health care service providers accepting payment for services from the Plan, in consideration of such payments, further agree to submit claims for reimbursement in strict accord with their state's health care practice acts, ICD-10, or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator.

Any claims not paid in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur a pre-judgment interest rate of 1 ½% per month. The Plan shall be entitled to litigation costs and actual attorney fees in the event it becomes necessary to institute suit to recover duplicate or erroneous payments or payments of improperly billed charges.

Conformity With Applicable Law

This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document.

Clerical Error

Clerical errors, such as inaccurate transcription of premiums, Effective Dates, termination dates, or such as erroneous mailings, shall not change the rights or obligations of any party under the Plan and shall not operate to grant additional benefits to Plan Members.

Fraud

The following actions by any Plan Member, or a Plan Member's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for that Plan Member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Plan Member in the Plan;
2. Attempting to file a claim for a Plan Member for services which were not rendered or drugs or other items that were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

No Waiver

The failure of the Plan Administrator to strictly enforce any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Plan Administrator reserves the right to strictly enforce each and every provision of this Plan at any time regardless of the prior conduct of the Plan Administrator and regardless of the similarity of the circumstances or the number of prior occurrences.

Plan Contributions

The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed by each Plan Member.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be free to determine the manner and means of funding the Plan. The amount of the Plan Member's contribution will be determined from time to time by the Plan Administrator.

Booklets

The Plan Administrator has issued to each Employee an individual booklet, which summarizes the benefits to which the person is entitled, to whom benefits are payable, and the provisions of the Plan affecting the Plan Members.

Entire Plan

The Plan including any amendments, the Schedule of Coverage, any other applicable schedules, the attached papers, and the individual applications, if any, of the Employees and eligible Dependents, constitute the entire description of benefits between the parties and any statement made by the Employer or by any Employee shall not, in any way, change such benefits.

All statements made by the Employer or by a Plan Member shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this Plan or be used in defense of a claim unless they are contained in writing and signed by the Employer or by the Plan Member, as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such contest.

Plan Modification and Amendment

The City Manager of the Company shall be empowered to amend this Plan or any benefit under this Plan at any time by a written instrument signed by the City Manager. An increase or decrease in Plan benefits will become effective as of the date specified in the Plan or in an applicable amendment.

The Plan will furnish each Plan Member with a summary of any material reductions in covered services or benefits not later than 60 days after the effective date of such change.

Plan Termination

The City Manager of the Company may terminate the Plan at any time. Upon termination, the rights of the Plan Members to benefits are limited to claims Incurred and due up to the date of termination. Any termination of the Plan will be communicated to Plan Members.

Assignment

The Plan Member's benefit payments may not be assigned except by consent of the Company to other than suppliers of medical services.

Automatic Assignment

All medical/**dental** expense benefits payable under this Plan shall be paid to the medical/**dental** service provider, unless the claimant furnishes proof of payment of the medical/**dental** expenses at the time the claim is filed with the Claims Administrator, in which case the benefits shall be paid to the claimant.

Physical Examination

The Plan at its own expense shall have the right and opportunity to examine any Plan Member, whose Injury or Sickness is the basis of a claim, as often as it may reasonably require while a claim is pending.

Disclosure Of Electronic Protected Health Information (“Electronic PHI”) To The Plan Sponsor For Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

1. Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI; and
4. Report to the Plan any Security Incident of which it becomes aware.

Any terms not otherwise defined shall have the meanings set forth in the Security Standards.

Privacy Standards

1. Disclosure of Summary Health Information to the Plan Sponsor.

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

“Summary Health Information” may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

2. Disclosure of Protected Health Information (“PHI”) to the Plan Sponsor for Plan Administration Purposes.

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

- a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);
- b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
- d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- e. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);
- f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

- g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
- h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);
- i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- j. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - i. The following Employees or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

HR Department
City Manager
 - ii. The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
 - iii. In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Document relating to use and disclosure of PHI, the Plan Sponsor shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

“Plan Administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan Administration” functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

3. Disclosure of Certain Enrollment Information to the Plan Sponsor.

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan.

4. Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage.

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

5. Other Disclosures and Uses of PHI.

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

SECTION L

SUBROGATION/RIGHT OF REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Members, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Member(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Plan Member(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Plan Member(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Member(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Plan Member(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Plan Member shall be a trustee over those Plan assets.

In the event a Plan Member(s) settles, recovers, or is reimbursed by any Coverage, the Plan Member(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Member(s). If the Plan Member(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Member(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Member(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Plan Member(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Member(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Plan Member(s) fails to so pursue said rights and/or action.

If a Plan Member(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Member(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Plan Member is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Plan Member is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Plan Member(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Plan Member(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

the Plan Member(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Member's/Plan Members' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Member(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, without regard to whether the Plan Member(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Member's/Plan Members' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Plan Member are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Plan Member's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Plan Member is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Member(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Member(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, disease or disability.

Plan Member is a Trustee Over Plan Assets

Any Plan Member who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Plan Member understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Plan Member is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Member obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Plan Member disputes this obligation to the Plan under this section, the Plan Member or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Plan Member, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

If at the time of Injury, Sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Plan Member(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Member(s), such that the death of the Plan Member(s), or filing of bankruptcy by the Plan Member(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Plan Member(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Plan Member(s) and all others that benefit from such payment.

Obligations

It is the Plan Member's/Plan Members' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.

7. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Member may have against any responsible party or Coverage.
8. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
9. In circumstances where the Plan Member is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Member obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
10. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Plan Member over settlement funds is resolved.

If the Plan Member(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Plan Member(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Member(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Member's/Plan Members' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Plan Member and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Plan Member's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Plan Member(s) in an amount equivalent to any outstanding amounts owed by the Plan Member to the Plan. This provision applies even if the Plan Member has disbursed settlement funds.

Minor Status

In the event the Plan Member(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

SECTION M

CLAIM/APPEAL PROCEDURES

The procedures outlined below must be followed by Plan Members ("claimants") to obtain payment of health benefits under this Plan.

All claims and questions regarding health claims should be directed to the Claims Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the claimant is entitled to them. The responsibility to process claims in accordance with the Master Plan Document and summary plan description may be delegated to the Claims Administrator; provided, however, that the Claims Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion. The Plan Administrator has retained the services of an independent third party administrator, EBSO, Inc. ("Claims Administrator") to provide technical services, including the processing of claims.

Each Plan Member claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator, in its sole discretion may require, written proof that the expenses were Incurred and that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the claimant has not Incurred a Covered Expense or that the benefit is not covered under the Plan, or if the claimant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

Under the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

Definitions

Words which are capitalized in this document are either defined below or in the Master Plan Document (see Definitions of General Terms, General Information and General Provisions) and summary plan description.

Pre-service Claims:

A "Pre-service Claim" arises when there is a claim for a benefit under the Plan and the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A "Pre-service Urgent Care Claim" arises when there is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant

or the claimant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

It is important to remember that, if a claimant needs medical care for a condition which could seriously jeopardize his life, there is no need to contact the Plan for prior approval. The claimant should obtain such care without delay.

Further, if the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Concurrent Claims:

A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the claimant requests extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Post-service Claims:

A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed

Health claims must be filed with the Claims Administrator within six months of the date charges for the service were incurred. However in no event, except in the absence of legal capacity, will claims be accepted later than 12 months from the date the charge in question was incurred. Charges are considered incurred when treatment or care is given or supplies are provided. **Claims filed later than that date shall be denied.**

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Utilization Review Organization in accordance with the Plan's Utilization Review procedures.

However, a Post-service Claim is considered to be filed when the following information is received by the Claims Administrator, together with a Form HCFA, Form UB92 or Form ADA:

1. The date of service;
2. The date the Injury or Sickness began;
3. The name, address, telephone number and tax identification number of the provider of the services or supplies;
4. The place where the services were rendered;
5. The diagnosis and procedure codes;
6. The amount of charges;
7. The name of the Plan and Plan ID #;
8. The name and home address of the Employee;
9. The Employee's social security number;
10. The name and home address of the patient; and
11. The patient's social security number.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Utilization Review Organization will determine if enough information has been submitted to enable proper consideration of the Pre-service Claim or Pre-service Urgent Claim. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the post-service claim. If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within 45 days (or by the Utilization Review Organization within 48 hours in the case of Pre-service Urgent Care Claims) from receipt by the claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

NOTE: The Plan does not consider inquiries about benefits, eligibility or the circumstances under which benefits might be paid, to be claims. An inquiry does not become a claim unless the proper claim procedure is followed. Further, questions concerning eligibility for benefits, such as calls from providers of medical services, are NOT ever considered claims.

Timing of Claim Decisions

The Plan Administrator shall notify the claimant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

Pre-service Urgent Care Claims:

If the claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim. The claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded the claimant to provide the information.

Pre-service Non-urgent Care Claims:

If the claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the claimant (if additional information was requested during the extension period).

Concurrent Claims:

Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The claimant will be notified sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving Urgent Care and decided within the Urgent Care timeframe.

Request by Claimant Involving Non-urgent Care. If the Plan Administrator receives a request from the claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

Post-service Claims:

If the claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If the claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the claimant will be notified of the determination by a date agreed to by the Plan Administrator and the claimant.

Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service Urgent Care Claims.

Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a claimant with a notice, either in writing or electronically (or, in the case of Pre-service Urgent Care Claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), containing the following information:

1. A reference to the specific portion(s) of the Master Plan Document and summary plan description upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the claimant's right to bring a civil action following an adverse benefit determination on final review;
5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;
6. The identity of any medical, dental or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the claimant, free of charge, upon request);
8. In the case of denials based upon a medical judgment (such as whether the treatment is Medical Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided to the claimant, free of charge, upon request; and
9. In a claim involving Urgent Care, a description of the Plan's expedited review process.

Requested copies will be provided to the claimant within a reasonable period of time, not to exceed 30 days from the date the Plan receives the written request for copies.

Appeal of Adverse Benefit Determinations – Internal Review

A. Procedures for Review of Adverse Benefit Determinations

In cases where a claim for benefits is denied, in whole or in part, and the claimant believes the claim has been denied wrongly, the claimant may appeal the denial and review relevant documents. The claims procedures of this Plan provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. Claimants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination. If the claimant does not appeal on time, he/she will lose the right to file suit in court and will have failed to exhaust the Plan's internal administrative appeal procedures, which is generally a prerequisite to bringing suit;
2. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. For a review that is independent from the initial adverse benefit determination and is conducted by an appropriate named fiduciary of the Plan who is not the same individual who decided the claimant's initial adverse benefit determination and who is not also that individual's subordinate;
4. For a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
5. That, if an adverse benefit determination is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with an independent health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is not the same person as the health care professional consulted in connection with the initial adverse benefit determination;
6. For the identity of medical/vocational experts consulted in connection with the appeal, even if the Plan did not rely upon their advice; and
7. In an Urgent Care Claim, for an expedited review process pursuant to which:
 - a. A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

- b. All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

B. Requirements for Appeal

The claimant must file the appeal in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) within 180 days following receipt of the notice of an initial adverse benefit determination. For Pre-service Urgent Care Claims, if the claimant chooses to orally appeal, claimant may telephone: Appeal Dept. EBSO, Inc. at 800-558-7798. To file an appeal in writing, the claimant's appeal must be addressed as follows and mailed and/or faxed to the following number: *Attention: Appeal Dept. c/o EBSO, Inc. 215 Stanford Parkway, Findlay, OH 45840. Fax (419) 423-5834.*

It shall be the responsibility of the claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee;
2. The name of the claimant;
3. The Employee's social security number;
4. The claimant's social security number;
5. The group name and identification number;
6. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories which support this claim if the claimant fails to include them in the appeal;**
7. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
8. Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.

If the claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

C. Notification of Benefit Determination on Review

The Plan Administrator shall notify the claimant of the Plan's benefit determination on review within the following timeframes:

Pre-service Urgent Care Claims: As soon as possible, taking into account the medical

exigencies, but not later than 72 hours after receipt of the appeal.

Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – Pre-service Urgent, Pre-service Non-urgent or Post-service.

Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

D. Manner and Content of Notification of Adverse Benefit Determination on Review.

The Plan Administrator shall provide a claimant with notification, with respect to Pre-service Urgent Care Claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Master Plan Document and summary plan description on which the denial is based;
3. The identity of any medical, dental or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided free of charge upon request;

7. A description of any available External Review process and how to initiate an External Review;
8. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office or the Plan Administrator."

If, for any reason, the claimant does not receive a written response to the appeal within the appropriate time period set forth above, the claimant may assume that the appeal has been denied and the Plan's internal review procedures have been exhausted.

Appeal of Adverse Benefit Determinations – External Review

A. Overview

If the claim is denied, the claimant may be eligible to have his/her claim reviewed by an Independent Review Organization (IRO) pursuant to a process called "External Review." Generally, External Review is available only after the claim denial has been upheld after the final level of appeal under the Plan. The claimant may, however, in limited circumstances have the right to have the claim reviewed by an IRO prior to exhausting the Plan's appeal process. See **Expedited External Review** for further details.

B. Request for Review

External Review is available only for medical claims (excluding dental and vision) that involve medical judgment (including, for example, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination as to whether a treatment is experimental or investigational) and for rescissions of coverage (i.e. retroactive cancellations of coverage because of the Plan Member's fraud or intentional misrepresentation of a material fact regarding eligibility for coverage).

Federal government agency guidance may further limit or broaden the scope of External Review. The Plan will provide an External Review process in accordance with applicable guidance.

A request for External Review must be filed in accordance with the instructions contained in the claimant's appeal denial notice and must be received not later than four months after the date he/she receives the appeal denial notice. If there is no corresponding date four months after the date of the appeal denial notice, then the request must be filed by the first day of the fifth month following receipt of the notice. For example, if the date of the denial notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

C. Preliminary Review

Within five business days after receiving the claimant's External Review request, the Plan Administrator will complete a preliminary review to determine whether his/her request is complete and eligible for External Review. That preliminary review will determine: whether the claimant was covered under the Plan at the time the item or service was requested or provided; whether the final denial of his/her appeal related to the claimant's failure to meet the Plan's eligibility requirements; whether the claimant exhausted the Plan's internal appeal process (or are not required to exhaust the process); and whether the claimant has provided all the information and forms required to process an External Review.

Within one business day after the completion of the preliminary review, the Plan Administrator will notify the claimant of one of the following:

1. That his/her request is complete, but she/he is not eligible for external review. This notice will state the reasons for the ineligibility and provide contact information for the Employee Benefits Security Administration.
2. That his/her request is incomplete, but may still be eligible for external review. This notice will describe the information or materials needed to complete the request. The claimant will be permitted to provide the required information by the later of: (a) the last day of the four month filing period or (b) 48-hours after receipt of the notice.
3. That his/her request is complete and eligible for external review.

D. Referral to IRO

If the claimant's request for External Review is complete and eligible, the Plan Administrator will assign a qualified IRO to conduct the External Review and within five business days after making the assignment will provide the IRO with the documents and information the Plan Administrator considered in making its final appeal denial.

The claimant will have at least 10 days to submit additional information to the IRO. If the claimant submits additional information, the IRO will send that information to the Plan and the Plan may reconsider its determination. If the Plan decides, on reconsideration, to reverse its benefits denial and provide coverage or payment, then the external review can be terminated.

If the Plan does not reverse its determination, the IRO will review all of the information and documents timely received. In reaching a decision the IRO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeal process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate will

consider the following in reaching a decision: the claimant's medical records; the attending health care professional's recommendation; reports from the appropriate health care professionals and other documents submitted by the Plan Administrator, the claimant's treating provider; the terms of the Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan; appropriate practice guidelines; any applicable clinical review criteria developed and used by the Plan; and the opinion of the IRO's clinical reviewer(s).

The IRO must provide written notice to the claimant and the Plan Administrator of the final External Review decision within 45 days after the IRO receives the request for External Review. If the IRO reverses the Plan's determination, the Plan must immediately provide coverage or payment for the claim.

E. Expedited External Review

Under the following circumstances, the claimant may be eligible to file for an expedited External Review:

1. If the claimant receives a claim denial that involves a medical condition for which the timeframe for completion of an expedited internal appeal with the Plan Administrator would seriously jeopardize the claimant's life or health, or that would jeopardize the claimant's ability to regain maximum function, and the claimant has filed a request for an expedited internal appeal; or
2. If the claimant receives a final appeal denial from the Plan Administrator and: he/she has a medical condition for which the timeframe for completion of a standard external appeal would seriously jeopardize his/her life or health, or would jeopardize his/her ability to regain maximum function; or if the final claim denial concerns an admission, availability of care, continued stay, or health care item or service for which the claimant has received emergency services but have not been discharged from a facility.

Immediately upon receipt of the request for an expedited External Review, the Plan Administrator will complete a preliminary review of the claimant's request in order to determine his/her eligibility for expedited External Review. Immediately after completion of the preliminary review, the Plan Administrator will issue the claimant a written notification of his/her eligibility for expedited External Review. If the claimant's request is complete but not eligible for External Review, the notice will include the reasons for ineligibility. If the claimant's request is incomplete, the notice will describe the information or materials needed to make the request complete and the claimant will have an opportunity to complete the request.

Upon a determination that a request is eligible for expedited External Review, the Plan Administrator will assign an IRO for review and transmit all necessary documents and

information to the IRO. The IRO must provide notice, to the claimant and the Plan Administrator of the final External Review decision as expeditiously as possible, but in no event later than 72 hours after the IRO receives the request for the expedited External Review.

All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.

Appointment of Authorized Representative

A claimant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the claimant must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. **In the event a claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the claimant, unless the claimant directs the Plan Administrator, in writing, to the contrary.**

MASTER PLAN DOCUMENT AMENDMENT #1
(Dental – Mexico Coverage)

Effective July 1, 2019, the Master Plan Document and Summary Plan Description for City of San Luis – Dental Plan - Mexico Coverage is hereby amended as follows:

SCHEDULE OF COVERAGE, is hereby deleted and replaced with Attachment A

DEFINITIONS OF GENERAL TERMS, EMPLOYEE, is hereby deleted replaced with the following:

EMPLOYEE means an Employee of the Employer who is regularly scheduled to actively perform the principle duties of his/her occupation a minimum of 30 hours per week, and who is enrolled and eligible for coverage under the Plan. Employee also included Council Members who are working a minimum of 20 hours per month.

Part-time, seasonal, temporary and retired employees are not eligible for coverage under the Plan. Employee does not include the following:

1. a self-employed individual as described in Section 401 (c) of the Code, including, but not limited to, a sole proprietor if the Employer is a sole proprietorship, a person owning more than 2% of the Employer if it is a Subchapter S corporation, a partner of the Employer if it is a partnership, and a member of the Employer if it is a limited liability company and the members are treated as partners for income tax purposes;
2. an employee who is a spouse, child, grandchild, or parent of a person owning more than 2% of the Employer if it is a Subchapter S corporation;
3. any individual included within a unit of employees covered by a collective bargaining unit unless such agreement expressly provides for coverage of the Employee under the Plan;
4. any individual who is a nonresident alien and receives no earned income from the Employer from sources within the United States;
5. any individual who is a leased employee as defined in Section 414(n)(2) of the Code;
6. any individual who performs services for the Employer through, and is paid by, a third-party (including but not limited to an employee leasing or staffing agency) even if such individual is subsequently determined to be a common law employee of the Employer; or
7. any individual who performs services for the Employer pursuant to a contract or agreement (whether verbal or written) which provides that such individual is an independent contractor or consultant, even if such individual is subsequently determined to be a common law employee of the Employer.

DENTAL BENEFITS, is hereby deleted and replaced with the following:

DENTAL BENEFITS

Covered Dental Expenses

The Plan will pay benefits for Covered Expenses Incurred by a Plan Member for the following dental services, only when performed by a Dentist or a Dental Hygienist, or other dental provider working under the direction and supervision of the Dentist. The payment is subject to the General Limitations and Exclusions and all other provisions of the Plan.

Class I Services –Preventive and Diagnostic Services

- D0120 Follow up exam every 6 months
- D0140 Emergency exam
- D0145 Oral evaluation for a patient under age 3/counseling with primary caregiver
- D0150 Initial oral exam
- D0160 Detailed and extensive oral evaluation-problem focused, by report
- D0170 Re-evaluation limited problem focused (establish patient)
- D0210 Intraoral complete series (including Bitewings)
- D0220 Intraoral single/firts film 1
- D0230 Intraoral periapical each film
- D0240 Intraoral occlusal film each
- D0270 Bitewing single film
- D0272 Bitewings - two films
- D0273 Bitewings - three films
- D0274 Bitewings - four films
- D0277 Vertical bitewings
- D0330 Panoramic radiographic image
- D0431 Adjunctive pre-diagnostic test (mucosal lesions)
- D1351 Appl sealant per tooth
- D1110 Adult prophylaxis
- D1120 Child prophylaxis
- D1208 Topical application of fluoride
- D2910 Re-cement inlay
- D2920 Re-cement crown
- D2940 Sedative filling
- D2950 Core buildup, including any pins

Class I Services –Limitations

- Teeth cleaning – limited to 2 times per Calendar Year
- Exams – limited to 2 times per Calendar Year
- Dental x-rays
 - o Full or Panoramic – limited to once in any 36 consecutive month period

- o Bitewings films, maximum of 4 films per visit – limited to 2 sets of x-rays per Calendar Year
 - o Vertical bitewing x-rays – limited to 1 set every 3 years
- Fluoride treatments – limited to children under age 16 and to 1 treatment per Calendar Year
- Sealants – limited to unrestored permanent molars of Plan Members under 16 years of age and to one treatment per tooth in any 36 consecutive months
- Office visits, during regular hours – problem focus exams – limited to 2 visits per Calendar year

Class II Services – Basic Services

- D0322 Tomographic survey
- D0480 Accession of exfoliative cytologic smears (written report)
- D1510 Space maintainer - fixed bilateral
- D1515 Space maintainer - fixed unilateral
- D2140 Amalgam one surf/permanent or primary
- D2150 Amalgam two surf/permanent or primary
- D2160 Amalgam three surf/permanent or primary
- D2161 Amalgam four surf/permanent or primary
- D2330 Composite resin one surface anterior
- D2331 Composite resin two surface anterior
- D2332 Composite resin three surface anterior
- D2335 Composite resin four or more surfaces
- D2390 Resin based composite crown, anterior
- D2391 1 surface resin based composite
- D2392 2 surface resin based composite
- D2393 3 surface resin based composite
- D2394 4 or more surface resin based composite
- D2954 Post & core
- D2957 Each additional prefabricated post- same tooth
- D2960 Labial veneer (resin laminate)- chairside
- D2961 Labial veneer (resin laminate)- laboratory
- D2962 Labial veneer (porcelain laminate)- laboratory
- D3110 Pulp cap - direct (excluding final restoration)
- D3120 Pulp cap - indirect (excluding final restoration)
- D3220 Therapeutic pupotom (excluding final restoration)
- D3221 Pulpal debridement primary and permanent
- D3230 Pulpal therapy - anterior, primary tooth
- D3240 Pulpal therapy - posterior, primary tooth
- D3310 Anterior root canal
- D4211 Gingivectomy/plasty - one to three contiguous teeth, per quad
- D4240 Gingival flap procedure - four or more contiguous teeth or tooth per quad
- D4341 Periodontal scaling & root planning per quadrant
- D4342 Periodontal scaling and root planing - one to three teeth per quad.

- D4355 Full mouth debridement
- D4910 Periodontal maintenance, following active therapy
- D5650 Add tooth to existing partial denture
- D5660 Add clasp to existing partial denture
- D5710 Rebase complete lower denture
- D5711 Rebase complete upper denture
- D5720 Rebase upper partial denture
- D5721 Rebase lower partial denture
- D5730 Reline complete upper denture (chairside)
- D5731 Reline complete lower denture (chairside)
- D5740 Reline upper partial denture (chairside)
- D5741 Reline lower partial denture (chairside)
- D6930 Recement fixed partial bridge
- D7111 Extraction baby tooth
- D7140 Extraction erupted tooth (adult)
- D7210 Surgical removal erupted tooth
- D7220 Soft tissue impaction
- D7230 Partially bony impaction
- D7250 Surgical removal of residual tooth roots (cutting proc.)
- D7910 Suture recent small wound (5cm)
- D7950 Osseous, osteo perio graft
- D7960 Frenulectomy

Class III Services – Major Dental Repair Services

- D2642 Onlay - porcelain/ceramic - 2 surface
- D2643 Onlay - porcelain/ceramic - 3 surface
- D2644 Onlay - porcelain/ceramic - 4 surface
- D2722 Crown - resin with noble metal
- D2740 Crown - porcelain/ceramic
- D2750 Crown - porcelain w/gold
- D2751 Crown - porcelain fused to predominantly base metal
- D2752 Crown - porcelain fused to noble metal
- D2790 Gold (full cast) crowns
- D2799 Provisional crown-temporary restoration of least six months
- D2930 Stainless crown (primary)
- D2931 Stainless steel crown-per tooth
- D2932 Prefabricated resin crown
- D3320 Bicuspid root canal
- D3330 Root canal therapy - molar
- D3346 Retreatment root canal anterior (one root)
- D3347 Retreatment root canal bicuspid (two roots)
- D3348 Retreatment root canal molar (three roots)
- D3410 Apicoectomy (per tooth) anterior
- D3421 Apicoectomy/periradicular surgery - bicuspid
- D3425 Apicoectomy/periradicular surgery - molars

- D3426 Apicoectomy/periradicular surgery - (each additional root)
- D4210 Gingivectomy/plasty - four or more contiguous teeth, per quad
- D4241 Gingival flap procedure -one to three contiguous teeth or tooth per quad
- D4249 Clinical crown lengthening - hard tissue
- D4260 Osseous surgery- four or more contiguous teeth or tooth
- D4261 Osseous surgery- one to three contiguous teeth or tooth
- D4263 Bone replacement graft–retained natural tooth-first site in quad.
- D4264 Bone replacement graft - multisite
- D4273 Subepithelial tissue graft procedure subepithelial
- D4321 Provisional splinting-extra coronal
- D5110 Complete denture, upper - once every 5 years
- D5120 Complete denture, lower - once every 5 years
- D5130 Immediate upper dentures - lifetime benefit
- D5140 Immediate lower dentures - lifetime benefit
- D5211 Maxillary partial denture/resin base
- D5212 Mandibular partial denture/resin base
- D5213 Upper partial denture/metal frame work w/resin
- D5214 Lower partial denture/metal frame work w/resin
- D5281 Remove unilat part/one piece cast metal
- D5820 Interim partial denture (upper)
- D5821 Interim partial denture (lower)
- D6242 Pontic - porcelain fused to noble metal
- D6740 Crown - porcelain
- D6750 Crown - porcelain fused to high noble metal
- D6751 Crown - porcelain fused to predominantly base metal
- D6752 Crown - porcelain fused to noble metal
- D7240 Completely bony impaction
- D7241 Removal of impacted tooth - completely bony
- D7272 Surgical tooth transplantation
- D7286 Biopsy of oral tissue - soft
- D7472 Removal of torus palatinus
- D7473 Removal of torus mandibular
- D7485 Surgical reduction of osseous tuberosity

Class III Services –Limitations

- Denture repairs, adjustments, relines or rebase – limited to adjustments made more than 6 months after the initial installation. Rebase is limited to once per 36 consecutive month period. Reline is limited to once per 12 consecutive month period.
- Complete and partial dentures. Immediate dentures are limited to one set per Lifetime.

NOTE: The Plan covers the replacement of an existing denture or bridge only if the existing denture or bridge is unserviceable and cannot be

made serviceable. The Plan pays the benefit level that applies to the cost of services necessary to make the appliances serviceable. The plan will cover replacement of prosthodontic appliances only if at least 5 years have elapsed since the date of the initial insertion of that appliance.

Class IV Services – Orthodontic Services.

NOTE: Dependent children must be covered under the Dental Plan for twelve (12) consecutive months before orthodontia benefits are available.

- D0340 cephalometric film
- D0350 panoramic film
- D0470 diagnostic cast
- D8030 limited orthodontic treatment of the adolescent dentition
- D8670 periodic orthodontic treatment visit cast part of contract

Any other Class I, II, III, or V services that are performed in connection with orthodontic treatment shall be payable under their appropriate payment percentage and not included under the orthodontic limitations and/or payment percentages.

Class V Services – Other Services.

- D9223 Deep sedation/general anesthesia-each additional 15 minutes
- D9230 Analgesia, anxiolysis, inhalation of nitrous oxide
- D9910 Application of desensitizing medicament
- PH101 Pharmacy Rx

Accepted By:

Name:	Title	Date
For: City of San Luis		

SCHEDULE OF COVERAGE

NOTE: THIS IS ONLY A SUMMARY, SPECIFIC SERVICES AND SUPPLIES MAY BE SUBJECT TO COPAYS, MAXIMUM BENEFIT PAYMENTS, USUAL, CUSTOMARY AND REASONABLE FEES AND/OR EXCLUSIONS AND LIMITATIONS.

NOTE: Benefits under this Plan will be paid only if the Plan Administrator decides in his/her discretion that the individual is entitled to them.

DENTAL BENEFITS – NETWORK ONLY

Copays

Class I Services – Diagnostic and Preventive Care	\$10
Class II Services - Basic Services	\$20
Class III Services - Major Services	\$50
Class IV Services – Orthodontics	None
Class V Services – Other Services	
Pharmacy Rx	
Generic	\$3
Name Brand	\$6
All other Class V Services	None

Payment Percentages after Copay is met

Class I Services – Diagnostic and Preventive Care	100%
Class II Services - Basic Services	100%
Class III Services - Major Services	100%
Class IV Services – Orthodontics	50%
Class V Services – Other Services	100%

Maximum Benefits

Per Calendar Year for Class I, II, III & V Services, combined	\$1,000
Per Lifetime for Class IV Services	\$1,000

NOTE: Orthodontic Services are **LIMITED** to Dependent children less than 19 years of age. Dependent children must be covered under the Plan for 12 consecutive months before orthodontic services are available.

THE NETWORK IS ADMINISTERED BY: SIARMED



AGENDA ITEM REVIEW FORM

Special City Council Meeting

5.F.

Meeting Date: 06/25/2019

Department Head: Kay Macuil, City Attorney, Attorney's Office

Submitted By: Kay Macuil, City Attorney, Attorney's Office

Action Requested: Motion

ITEM:

Discussion and possible action on any and all matters regarding the annual pension funding policy for public safety personnel required by HB 2097. **(Monica Castro, Finance Director)**

SUMMARY:

The Governor signed HB 2097 on April 3, 2018, now A.R.S. § 38-863.01. It requires that cities annually adopt a pension funding policy for public safety personnel (police and fire) hired before July 1, 2017. The law prescribes the contents of the policies. The Finance Director has prepared the policies for public safety personnel of the Police and Fire Departments compliant with these requirements.

The law further requires that the City Council formally accept the city's share of the assets and liabilities under the Arizona Public Safety Personnel Retirement System ("System") based on the System's actuarial valuation.

Finally, the law requires that the City Council post the policies on the city's official website.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO:

- **ADOPT THE PENSION FUNDING POLICIES AS PRESENTED,**
- **ACCEPT THE CITY'S SHARE OF THE ASSETS AND LIABILITIES UNDER THE ARIZONA PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM'S ACTUARIAL VALUATION REPORT, AND**
- **ORDER THAT THE APPROPRIATE CITY STAFF POST THE PENSION FUNDING POLICIES ON THE CITY'S WEBSITE.**

N/A

Fiscal Impact

IS THERE FISCAL IMPACT ASSOCIATED WITH THIS ITEM:	N/A
CITY/STATE/FEDERAL FUNDS:	N/A
TOTAL:	N/A
BUDGETED AMOUNT:	N/A
AVAILABLE AMOUNT TO TRANSFER:	N/A
ACCT NAME & GL#/REMAINING BALANCE BEFORE PURCHASE:	N/A

FISCAL IMPACT STATEMENT (IF THIS IS A BUDGET TRANSFER, YOU MUST ATTACH THE BUDGET ADJUSTMENT FORM):

The Council's PSPRS funding ratio goal is 100% (fully funded) by June 30, 2036. Council established this goal for the following reasons:

- The PSPRS trust funds represent only the City of San Luis's liability
- The fluctuating cost of an UAAL causes strain on the City's budget, affecting our ability to provide services
- A fully funded pension is the best way to achieve taxpayer and member intergenerational equity

Council has taken the following actions to achieve this goal:

Maintain ARC payment from operating revenues – Council is committed to maintaining the full ARC payment (normal cost and UAAL amortization) from operating funds. The estimated combined ARC for FY19 is \$552,203 and \$377,580 for Police and Fire respectively, and will be able to be paid from operating funds without diminishing City services.

Based on these actions the Council plans to achieve its goal of 100% funding by June 30, 2036, in accordance with the amortization timeline set forth by the PSPRS June 30, 2017 Actuarial Valuation.

Attachments

Pension Policy COSL
ARS 38-863.01

City of San Luis

Public Safety Personnel Retirement System

Pension Funding Policy

The intent of this policy is to clearly communicate the Council's pension funding objectives and its commitment to our employees and the sound financial management of the City and to comply with new statutory requirements of Laws 2018, Chapter 112.

Several terms are used throughout this policy:

Unfunded Actuarial Accrued Liability (UAAL) – Is the difference between trust assets and the estimated future cost of pensions earned by employees. This UAAL results from actual results (interest earnings, member mortality, disability rates, etc.) being different from the assumptions used in previous actuarial valuations.

Annual Required Contribution (ARC) – Is the annual amount required to pay into the pension funds, as determined through annual actuarial valuations. It is comprised of two primary components: normal pension cost – which is the estimated cost of pension benefits earned by employees in the current year; and, amortization of UAAL – which is the cost needed to cover the unfunded portion of pensions earned by employees in previous years. The UAAL is collected over a period of time referred to as the amortization period. The ARC is a percentage of the current payroll.

Funded Ratio – Is a ratio of fund assets to actuarial accrued liability. The higher the ratio the better funded the pension is with 100% being fully funded.

Intergenerational equity – Ensures that no generation is burdened by substantially more or less pension costs than past or future generations.

The City's police and fire employees who are regularly assigned hazardous duty participate in the Public Safety Personnel Retirement System (PSPRS).

Public Safety Personnel Retirement System (PSPRS)

PSPRS is administered as an agent multiple-employer pension plan. An agent multiple-employer plan has two main functions: 1) to commingle assets of all plans under its administration, thus achieving economy of scale for more cost efficient investments, and invest those assets for the benefit of all members under its administration and 2) serve as the statewide uniform administrator for the distribution of benefits.

Under an agent multiple-employer plan each agency participating in the plan has an individual trust fund reflecting that agencies' assets and liabilities. Under this plan all contributions are deposited to and distributions are made from that fund's assets, each fund

has its own funded ratio and contribution rate, and each fund has a unique annual actuarial valuation. The City of San Luis has two trust funds, one for police employees and one for fire employees.

Council formally accepts the assets, liabilities, and current funding ratio of the City's PSPRS trust funds from the June 30, 2017 actuarial valuation, which are detailed below.

Trust Fund	Assets	Accrued Liability	Unfunded Actuarial Accrued Liability	Funded Ratio
San Luis Police	\$6,463,077	\$10,038,629	\$3,575,552	64.4%
San Luis Fire	\$5,155,291	\$ 6,127,969	\$ 972,678	84.1%
City of San Luis Totals	\$11,618,368	\$16,166,598	\$4,548,230	71.87%

PSPRS Funding Goal

Pensions that are less than fully funded place the cost of service provided in earlier periods (amortization of UAAL) on the current taxpayers. Fully funded pension plans are the best way to achieve taxpayer and member intergenerational equity. Most funds in PSPRS are significantly underfunded and falling well short of the goal of intergenerational equity.

The Council's PSPRS funding ratio goal is 100% (fully funded) by June 30, 2036.

Council established this goal for the following reasons:

- The PSPRS trust funds represent only the City of San Luis's liability
- The fluctuating cost of an UAAL causes strain on the City's budget, affecting our ability to provide services
- A fully funded pension is the best way to achieve taxpayer and member intergenerational equity

Council has taken the following actions to achieve this goal:

- Maintain ARC payment from operating revenues – Council is committed to maintaining the full ARC payment (normal cost and UAAL amortization) from operating funds. The estimated combined ARC for FY19 is \$552,203 and \$377,580 for Police and Fire respectively, and will be able to be paid from operating funds without diminishing City services.

Based on these actions the Council plans to achieve its goal of 100% funding by June 30, 2036, in accordance with the amortization timeline set forth by the PSPRS June 30, 2017 Actuarial Valuation.

[Arizona Revised Statutes Annotated](#)

[Title 38. Public Officers and Employees \(Refs & Annos\)](#)

[Chapter 5. Social Security and Retirement](#)

[Article 4. Public Safety Personnel Retirement System \(Refs & Annos\)](#)

A.R.S. § 38-863.01

§ 38-863.01. Pension funding policies; employers

Effective: August 3, 2018

[Currentness](#)

A. Beginning on or before July 1, 2019, each governing body of an employer shall annually:

1. Adopt a pension funding policy for the system for employees who were hired before July 1, 2017. The pension funding policy shall include funding objectives that address at least the following:

(a) How to maintain stability of the governing body's contributions to the system.

(b) How and when the governing body's funding requirements of the system will be met.

(c) Defining the governing body's funded ratio target under the system and the timeline for reaching the targeted funded ratio.

2. Formally accept the employer's share of the assets and liabilities under the system based on the system's actuarial valuation report.

B. The governing body shall post the pension funding policy on the governing body's public website.

Credits

Added by [Laws 2018, Ch. 112, § 1.](#)

§ 38-863.01. Pension funding policies; employers, AZ ST § 38-863.01

A. R. S. § 38-863.01, AZ ST § 38-863.01

Current through legislation effective June 7, 2019 of the First Regular Session of the Fifty-Fourth Legislature (2019).

End of Document

© 2019 Thomson Reuters. No claim to original U.S. Government Works.

Citing References

There are no Citing References for this citation.

Validity

There are no Validity results for this citation.

Bill Drafts

There are no Bill Drafts for this citation.

Notes of Decisions

There are no Notes of Decisions for this citation.



AGENDA ITEM REVIEW FORM

Special City Council Meeting

5.G.

Meeting Date: 06/25/2019

Department Head: Monica Castro, Director of Finance, Finance Department

Submitted By: Carlos Cortes, Assistant Director of Finance, Finance Department

Action Requested: Motion
Resolution

ITEM:

Public hearing followed by discussion and possible action on any and all matters regarding Resolution No. 2083. A resolution of the City of San Luis, Arizona, adopting the budget for Fiscal Year 2019 - 2020. **(Monica Castro, Director of Finance)**

- A. Open public hearing
 - 1. Staff Presentation
 - 2. Call to the Public on this Item
- B. Close public hearing
- C. Action on Resolution No. 2083

SUMMARY:

Pursuant to State Statute, the City Council is required to hold a public hearing before adopting the final budget that will establish the maximum ceiling for the City's budget.

Budget preparation workshops were held during the months of April and May, followed by the submission of a tentative recommended budget that was provided to City Council on June 12, 2019. At this point, staff has reviewed, revised, and compiled the data from all the work sessions for expected Fiscal Year 2019-20 revenues and expenditures. Therefore, we are submitting the final budget to Council for acceptance.

RECOMMENDATION / SUGGESTED MOTION:

A. I MOVE TO OPEN THE PUBLIC HEARING

- 1. Presentation by Staff
- 2. Call to the Public on this Item

B. I MOVE TO CLOSE THE PUBLIC HEARING

C. I MOVE TO APPROVE AND ADOPT RESOLUTION NO. 2083.

Supporting information is attached to this Agenda Item Review Form.

Fiscal Impact

IS THERE FISCAL IMPACT ASSOCIATED WITH THIS ITEM:	YES
CITY/STATE/FEDERAL FUNDS:	YES
TOTAL:	TBD
BUDGETED AMOUNT:	TBD
AVAILABLE AMOUNT TO TRANSFER:	N/A

ACCT NAME & GL#/REMAINING BALANCE BEFORE PURCHASE: TBD
FISCAL IMPACT STATEMENT (IF THIS IS A BUDGET TRANSFER, YOU MUST ATTACH THE BUDGET ADJUSTMENT FORM):
Monica please place your input

Attachments

Resolution 2083 Budget FY 2020



Resolution

OFFICE OF THE
MAYOR
CITY OF SAN LUIS

NO. 2083

RESOLUTION FOR THE ADOPTION OF BUDGET Fiscal Year 2019-2020

WHEREAS, in accordance with the provisions of Title 42, Chapter 17, Articles 1-5, Arizona Revised Statutes (A.R.S.), the City Council did, on June 25, 2019, make an estimate of the different amounts required to meet the public expenditures/expenses for the ensuing year, also an estimate of revenues from sources other than direct taxation, and

WHEREAS, in accordance with said chapter of said title, and following due public notice, the Council met on June 25, 2019, at which meeting any taxpayer was privileged to appear and be heard in favor of or against any of the proposed expenditures/expenses, and

WHEREAS, it appears that publication has been duly made as required by law, of said estimates together with a notice that the City Council would meet on June 25, 2019, at the office of the Council for the purpose of hearing taxpayer, therefore be it

RESOLVED, that the said estimates of revenues and expenditures/expenses shown on the accompanying schedules, as now increased, reduced, or changed, are hereby adopted as the budget of the City of San Luis for the fiscal year 2019-2020.

PASSED AND ADOPTED by the Mayor and City Council of the City of San Luis, Arizona, this 25th day of June, 2019.

Gerardo Sanchez, Mayor

ATTEST:

APPROVED AS TO FORM:

Sonia Cornelio, City Clerk

Kay Marion Macuil, City Attorney



AGENDA ITEM REVIEW FORM

Special City Council Meeting

8.

Meeting Date: 06/25/2019

Department Head: Kay Macuil, City Attorney, Attorney's Office

Submitted By: Kay Macuil, City Attorney, Attorney's Office

Action Requested: Motion

ITEM:

EXECUTIVE SESSION

Vote to hold an Executive Session pursuant to A.R.S. §§38-431.03(A)(3) and 38-431.03(A)(4)

Discussion and possible action to hold an Executive Session pursuant to A.R.S. §38-431.03(A)(3) and A.R.S. §38-431.03(A)(4) on any and all matters regarding consultation with the city's attorneys for legal advice and or in order for City Council to consider its position and instruct its attorneys regarding its position regarding contracts that are the subject of negotiations, in pending or contemplated litigation or in settlement discussions conducted in order to avoid or resolve litigation concerning the manganese filtration system at Well Site No. 7. **(Kay Marion Macuil, City Attorney)**

SUMMARY:

Mike Woodlock of the law firm of Gust Rosenfeld, P.C. has represented the city since November of 2017 on this complex set of contracts and warranties on the manganese filtration project on Well Site 7. As of the writing of this agenda item, electrical problems with the filtration system continue as a capacitor is in transit to fix the problem. But IWS has filed a lawsuit against the city to obtain the remaining retainage on the project. Mike Woodlock will be present by phone, and can properly advise the Council by holding an Executive Session for the purposes described in the agenda item.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO HOLD AN EXECUTIVE SESSION PURSUANT TO A.R.S. §§38-431.03(A)(3) AND 38-431.03(A)(4).

Supporting information is not attached to this Agenda Item Review Form.

Fiscal Impact

IS THERE FISCAL IMPACT ASSOCIATED WITH THIS ITEM: N/A

CITY/STATE/FEDERAL FUNDS: N/A

TOTAL: N/A

BUDGETED AMOUNT: N/A

AVAILABLE AMOUNT TO TRANSFER: N/A

ACCT NAME & GL#/REMAINING BALANCE BEFORE PURCHASE: N/A

FISCAL IMPACT STATEMENT (IF THIS IS A BUDGET TRANSFER, YOU MUST ATTACH THE BUDGET ADJUSTMENT FORM):

Fiscal impact is not applicable to this agenda item. Under A.R.S. §38-431.03(D), legal action involving a final vote or decision is not permitted to be taken at an executive session.



AGENDA ITEM REVIEW FORM

Special City Council Meeting

10.

Meeting Date: 06/25/2019

Department Head: Kay Macuil, City Attorney, Attorney's Office

Submitted By: Kay Macuil, City Attorney, Attorney's Office

Action Requested: Motion

ITEM:

DISCUSSION AND POSSIBLE ACTION ITEM:

Discussion and possible action on any and all matters regarding the approval and ratification to engage outside counsel to litigate Yuma County Superior Court Civil Case No. S1400 CV 2019 00321. **(City Council and Kay Marion Macuil, City Attorney)**

SUMMARY:

On May 22, 2019, IWS served the City of San Luis with a civil lawsuit regarding the manganese filtration project for Wellsite No. 7. This item is to ratify the answer and counterclaim filed by Outside Counsel Mike Woodlock (who has been working the case since November of 2017) and to authorize future representation on the city's behalf.

RECOMMENDATION / SUGGESTED MOTION:

I move to ratify and approve the engagement of Gust Rosenfeld Law Firm under the terms of the November 28, 2017 engagement letter, to represent and defend the City of San Luis and its officials and employees in any and all matters in the civil action Case No. S1400 CV 2019 00321, and to ratify the filing of the city's answer and counter-claim filed June 13, 2019 and the City's third-party complaint filed June 24, 2019, to represent and prosecute any and all counterclaims, and or thirdparty complaints against any person or entity that owe either a duty or damages to the City of San Luis arising out of the manganese filtration project for Wellsite No. 7, including but not limited to actions against:

Integrated Water Systems;

Tres Rios Consulting Engineers;

Engineered With Layton;

Darcor and Associates;

Jeff Bower;

any community of marriage of any named individual;

The Guarantee Company of North America, USA Surety;

Constructors Bonding, Inc. and or

any individual associated with the forgoing entities who bears legal responsibility.

N/A

Fiscal Impact

IS THERE FISCAL IMPACT ASSOCIATED WITH THIS ITEM:

Yes

CITY/STATE/FEDERAL FUNDS:

City

TOTAL:	\$19,330.75
BUDGETED AMOUNT:	\$19,330.75 FY 2020 Budget
AVAILABLE AMOUNT TO TRANSFER:	N/A
ACCT NAME & GL#/REMAINING BALANCE BEFORE PURCHASE:	100-117-80003 Legal Services \$19,330.75FY 2020

FISCAL IMPACT STATEMENT (IF THIS IS A BUDGET TRANSFER, YOU MUST ATTACH THE BUDGET ADJUSTMENT FORM):

On August 22, 2018, City Council approved a budget of \$30,000 for this issue. There is \$19,330.75 remaining in the budget to carry over into the 2020 fiscal year.

Attachments

Outside Counsel Contract
IWS's Complaint
City's Answer & Counter Claim
Minutes from 8-22-2018

*GUST
ROSENFELD*
ATTORNEYS SINCE 1921 P.L.C.

■ ONE E. WASHINGTON, SUITE 1600 ■ PHOENIX, ARIZONA 85004-2553 ■ TELEPHONE 602-257-7422 ■ FACSIMILE 602-254-4878 ■

Gary Verburg
602-257-7463
GVerburg@gustlaw.com

November 28, 2017

Kay Macuil, City Attorney
City of San Luis
1090 E. Union Street
P.O. Box 1170
San Luis, Arizona 85349

Re: Legal Representation – Integrated Water Matter

Dear Kay:

I am writing to acknowledge and thank you for retaining our law firm to represent the City of San Luis ("San Luis") as set forth below. It is our understanding that you have presently retained this firm to represent San Luis with respect to a construction dispute relating to design and installation problems of managed filtration wells.

I am enclosing for your information our "Terms of Engagement for Legal Services" Addendum which sets forth certain information concerning the business aspects of your retention of our firm. We hope that you find this information useful.

Michael Woodlock will serve as the attorney primarily responsible for this firm's representation of San Luis in this matter, and therefore will serve as your primary contact at this firm. As stated in the Addendum, other professionals will also provide services depending upon the way in which matters develop.

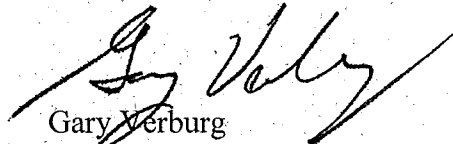
The Addendum sets forth the present range of standard hourly rates for me, our other attorneys, paralegals, law clerks and project assistants. Our firm will perform at a substantial discount over our standard rates. The discounted rate shall be \$240.00 per hour. Our standard hourly rates are subject to future changes as noted in the Addendum.

At this juncture, it is difficult to provide a useful estimate of the time (i.e., fees) and expenses necessary to undertake and complete this matter. However, as we proceed, we would be pleased to work with you to establish a budget for this matter if you so desire.

We appreciate being given the opportunity to serve you. Of course, if you have any questions or if there are any matters set forth in these documents which you would like to discuss, please contact me.

Once again, thank you for the confidence that you have placed in our firm by retaining us. We look forward to working with you.

Very truly yours,



Gary Verburg
For the Firm

GJV/bes

3125892

Attachment (Terms of Engagement for Legal Services)

GUST ROSENFELD P.L.C.

Terms of Engagement for Legal Services

This document sets forth the terms of our engagement as your lawyers. Unless modified in writing by mutual agreement, these terms are an integral part of our agreement with you. Therefore, we ask that you review this statement carefully. You should retain the original of this document. Please contact us promptly if you have any questions.

The Scope of Our Work

You should have a clear understanding of the legal services we will provide. Any questions that you have should be dealt with promptly.

We will at all times act on your behalf to the best of our ability. Any expressions on our part concerning the outcome of your legal matters are expressions of our best professional judgment, but are not guarantees. Such opinions are necessarily limited by our knowledge of the facts and are based on the state of the law at the time they are expressed.

Who Will Provide the Legal Services

Customarily, each client of the firm is served by a primary attorney contact. The primary attorney should be someone in whom you have confidence and with whom you enjoy working. You are free to request a change of primary attorney at any time. Subject to the supervisory role of the primary attorney, your work, or parts of it, may be performed by other lawyers and legal assistants in the firm. Such delegation may be for the purpose of involving lawyers or legal assistants with special expertise in a given area or for the purpose of providing services on the most efficient and timely basis. Whenever practicable, we will advise you of the names of those attorneys and legal assistants who work on your matters.

How Fees Will Be Set

The firm's fee structure is based upon hourly rates for all attorneys, paralegals and law clerks, unless otherwise specified. We record time expended on hourly fee matters in increments of one tenth of an hour, and calculate our fees on that basis.

Standard hourly rates for the firm presently range from \$225 to \$495 for attorneys; from \$200 to \$215 for paralegals; and \$160 for law clerks. These rates are

subject to increase, normally once per year. Advance notice of any increase will be provided in writing before any fees are charged at an increased rate.

Statements for services rendered will be submitted monthly, to more effectively monitor time and expenses as they are incurred. Our computerized billing format will provide you with a description of the efforts we have undertaken on your behalf.

We are often requested to estimate the amount of fees and costs likely to be incurred in connection with a particular matter. Whenever possible, we will furnish such an estimate based upon our professional judgment, but always with a clear understanding that it is not a maximum or fixed fee quotation. The ultimate cost frequently is more or less than the amount estimated.

For certain well-defined services we may quote a flat fee. It is our policy not to accept representations on a flat fee basis except in such defined-service areas or pursuant to a special arrangement tailored to the needs of a particular client. In all such situations, the flat fee arrangement will be expressed in a letter, setting forth both the amount of the fee and the scope of the services to be provided.

Out-of-Pocket Expenses

We typically incur, and advance on behalf of our clients, a variety of out-of-pocket costs arising in connection with legal services. These include charges made by government agencies and service vendors as well as clerical charges. Whenever such costs are incurred, we will carefully itemize and bill them. Typical of such costs are long distance telephone charges; messenger, courier, express delivery charges and certain other postage; facsimile; printing and reproduction costs; filing fees; deposition and transcript costs; witness fees; travel expenses; charges made by outside experts and consultants, including accountants, appraisers and other legal counsel (unless arrangements for direct billing have been made); and computer assisted legal research charges. We incur outside costs as agents for our clients and incur internal expenses on behalf of our clients, who agree to pay these costs on a regular basis.

Retainer and Trust Agreements

New clients of the firm are routinely asked to deposit a retainer with the firm. This retainer will be held in trust to be applied to the final bill. By mutual agreement it may be applied against earlier bills. At the conclusion of our legal representation or at such time as the deposit is unnecessary or is appropriately reduced, the remaining balance or an appropriate part of it will be returned to you. If the retainer deposit proves insufficient to cover current expenses and fees, it may have to be increased. Deposits that are received to cover specific items will be disbursed as provided in our

agreement with you, and you will be notified from time to time of the amounts applied or withdrawn.

All trust deposits we receive from you, including retainers, will be placed in a trust account for your benefit. By law, your deposit must be placed in a pooled account if it is not expected to earn a net return, taking into consideration the size and anticipated duration of the deposit and the transaction costs. Other trust deposits will also be placed in the pooled account unless you request a segregated account. By law, interest earned on the pooled account is payable to a charitable foundation established by the Arizona Supreme Court. Interest earned on a segregated trust account will be added to the deposit for your benefit and will be includable in your taxable income.

Termination

You may terminate our representation at any time, with or without cause by notifying us. If such termination occurs, your papers and property will be returned to you promptly. Our own files pertaining to the case will be retained. Your termination of our services will not affect your responsibility for payment of legal services rendered and out-of-pocket costs incurred before termination and in connection with an orderly transition of the matter.

We are subject to the Code of Professional Responsibility adopted by the Arizona Supreme Court, which lists several types of conduct or circumstances that require or allow us to withdraw from representing a client, including nonpayment of fees or costs, misrepresentation or failure to disclose material facts, action contrary to our advice, and conflict of interest with another client. We try to identify in advance and discuss with our clients any situation that may lead to our withdrawal, and if withdrawal ever becomes necessary, we immediately give the client written notice of our withdrawal.

Billing Arrangements and Terms of Payment

We will bill you on a regular basis, normally each month, for both fees and disbursements. You agree to make payment within 10 days of receiving our statement. Fees and disbursements not paid within 60 days are subject to a late charge of 1.5 percent per month (18% per annum).

We will give you prompt notice if your account becomes delinquent, and you agree to bring the account or the retainer deposit current. If the delinquency continues and you do not arrange satisfactory payment terms, we will withdraw from the representation and pursue collection of your account. You agree to pay the costs of collecting the debt, including court costs, filing fees, and a reasonable attorney's fee.

Binding Arbitration of Fee Disputes

If you disagree with the amount of our fee, please take up the question with your primary attorney contact or with the firm's executive committee. Typically, such disagreements are resolved to the satisfaction of both sides with little inconvenience or formality. Any dispute relating to payment of attorney fees which cannot be resolved in this manner shall be submitted to binding arbitration before the Committee of the State Bar of Arizona on Arbitration of Fee Disputes.

Notice Required by Law Regarding Privacy of Your Personal Information

Federal law requires financial service providers, which may include attorneys, to inform their non-business clients of their policies regarding protecting the privacy of client information. Gust Rosenfeld attorneys are bound by professional standards of confidentiality more stringent than those required by the Federal law. The Firm will protect our clients' confidential information.

Types of Nonpublic Personal Information That We Collect

We only collect nonpublic personal information about our clients that is provided to us by clients or obtained by us with their authorization.

Parties to Whom We Disclose Information

For current and former clients, we do not disclose any nonpublic personal information obtained in the course of our practice except as required by law or permitted by our clients.

Protecting the Confidentiality and Security of Current and Former Clients' Information

We retain records relating to professional services that we provide so that we are better able to assist our clients with their professional needs and, in some cases, to comply with professional guidelines. In order to guard clients' nonpublic personal information, we maintain physical and procedural safeguards that comply with professional standards for law firms.

PALECEK & PALECEK PLLC
ATTORNEYS AT LAW
6263 N. Scottsdale Rd., Suite 144
Scottsdale, Arizona 85250
Telephone: (602) 522.2454
Facsimile: (602) 522.2349
Karen A. Palecek #011944
kpalecek@paleceklaw.com
Attorneys for Plaintiff

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA
IN AND FOR THE COUNTY OF YUMA

INTEGRATED WATER SERVICES,
INC., a Colorado corporation,

Plaintiff,

v.

CITY OF SAN LUIS, a political
subdivision of the State of Arizona;
JOHN DOES 1-100, JANE DOES 1-
100, BLACK CORPORATIONS 1-
100, and WHITE PARTNERSHIPS 1-
100

Defendants.

CASE NO.

COMPLAINT

**(Breach of Contract, Unjust Enrichment,
Violation of Arizona's Public Prompt
Payment Act, Breach of the Covenant of
Good Faith and Fair Dealing)**

Plaintiff INTEGRATED WATER SERVICES, INC. ("IWS") by and through
undersigned counsel, for its Complaint against the above-named Defendant, alleges as
follows:

GENERAL ALLEGATIONS

1. Plaintiff IWS is a Colorado corporation authorized to do business in the
State of Arizona and the County of Yuma.
2. IWS is duly licensed by the Arizona Registrar of Contractors under a Class
A General Engineering license, License No. 224286, and a Class C-11 Electrical license,



1 License No. 258009.

2 3. Defendant CITY OF SAN LUIS ("SL") is an incorporated city located
3 within Yuma County, Arizona, under Title 9, Arizona Revised Statutes.

4 4. On or about December 7, 2018, IWS sent a Notice of Claim to the City of
5 San Luis pursuant to A.R.S. §12-821.01(A). A copy is attached hereto as Exhibit A and
6 incorporated herein by reference.

7 5. The Exhibit A Notice of Claim is in compliance with A.R.S. §12-821 and
8 §12-821.01.

9 6. This Court has jurisdiction over Defendant pursuant to Rule 4.1,
10 Ariz.R.Civ.P and IWS alleges that the service of the Notice of Claim complies with
11 A.R.S. §821.01(A), specifically that the person who has a claim against a public entity or
12 public employee shall file claims with the person or persons authorized to accept service
13 for the public entity as set forth in the Arizona Rules of Civil Procedure within 180 days
14 after the cause of action accrues.

15 7. The activity that is the subject of this Complaint took place within the City
16 of San Luis, Arizona.

17
18 **COUNT I**
19 **(Breach of Contract)**

20 8. Plaintiff IWS re-alleges and incorporates by reference the allegations
21 contained paragraphs 1 through 7 as if fully set forth herein.

22 9. On December 10, 2014, IWS entered into a construction contract for a
23 stipulated price in the amount of \$1,995,000.00 for the Well Site No.7-Manganese
24 removal system (the "Project"). A copy of the Contract is attached hereto as Exhibit B



1 and incorporated herein by reference.

2 10. As set forth in the Exhibit B Contract, the Contract provides for payment of
3 retention once two years has passed from the Certificate of Substantial Completion. See
4 Exhibit B, §4.02.

6 11. A Certificate of Substantial Completion was issued for the Project on
7 November 3, 2015. See Certificate attached hereto as Exhibit C and incorporated herein
8 by reference.

10 12. IWS billed for the retention on January 25, 2016. See Application for
11 Payment No. 11, attached hereto as Exhibit D and incorporated herein by reference.

12 13. IWS demanded final payment pursuant to Article 6.03(a) of the Contract on
13 November 22, 2017. See letter attached hereto as Exhibit E and incorporated herein by
14 reference.

16 14. Despite due demand, Defendant SL has failed and continues to refuse to pay
17 Plaintiff IWS the retention amounts due and owing.

18 15. Defendant SL's refusal to pay is a material breach of the Contract.

20 16. As a result of Defendant SL's material breach of the Contract, Plaintiff IWS
21 has been damaged in the principal amount of \$100,891.27.

22 17. Plaintiff IWS is also entitled to recover its reasonable attorneys' fees and
23 costs pursuant to the Exhibit B contract, specifically Article 10, ¶ 10.07 as well as A.R.S.
24 §12-341.01 as this matter arises out of contract.

26 18. Pursuant to Article 7 of the Exhibit B Contract and A.R.S. §34-221(J), IWS
27 is entitled to interest at the rate of 1% per month.

19. If this action is determined by Default Judgment, Plaintiff IWS requests attorneys' fees of no less than \$5,000.00, plus after-accruing fees and costs.

WHEREFORE, Plaintiff IWS respectfully requests that the Court enter judgment against Defendant SL for its breach of contract count as follows:

A. For principal damages in the amount of at least \$100,891.27, with applicable pre and post judgment interest at the highest legal rate until paid in full;

B. For costs and attorneys' fees incurred pursuant to Article 10, ¶ 10.07 of the contract and A.R.S. §12-341.01; and,

C. For interest at the rate of 1% per month pursuant to the Article 7 of the Contract and A.R.S. §34-221(J);

D. For such other and further relief as the Court deems just and proper.

COUNT II
(Unjust Enrichment)

20. Plaintiff IWS re-alleges and incorporates by reference the allegations contained in paragraphs 1 through 19 as if fully set forth herein.

21. Plaintiff IWS provided benefits to Defendant SL in the form of labor, equipment, and other services for which IWS has not been paid as outlined in the previous allegation.

22. IWS performed the work and anticipated being compensated for the work that benefitted Defendant SL.

23. The benefits referred to above were not conferred gratuitously but at the express request of Defendant SL and IWS had the expectation of being compensated for the work performed.

24. It would be inequitable and unjust for Defendant SL to retain those benefits conferred by IWS without paying for those benefits in full.

25. The reasonable value of the labor and materials for which Defendant SL has not paid Plaintiff IWS is \$100,891.27.

WHEREFORE, IWS respectfully requests that this Court enter judgment against Defendant SL for its second count of its Complaint as follows:

- A. Granting judgment for the reasonable value of the labor, materials, and equipment and service incorporated into the project in the principal amount of \$100,891.27, plus applicable pre and post judgment interest at the highest legal rate until paid in full.
- B. Awarding IWS its reasonable costs and attorneys' fees and pursuant to A.R.S. §12-341.01 and
- C. Costs and reasonable attorneys' fees;
- D. For interest at 1% per moth pursuant to A.R.S. §34-221(J);
- E. For such other and further relief as the Court deems just and proper.

COUNT III
(Breach of Covenant of Good Faith and Fair Dealing)

26. Plaintiff IWS re-alleges and incorporates by reference the allegations contained in paragraphs 1 through 25 of its Complaint, as if fully set forth herein.

1 27. As with all contracts in Arizona, the contract in this case carries an implied
2 covenant of good faith and fair dealing.

3 28. In this case, that covenant requires that Defendant SL would comply with
4 the terms set forth in the contract, specifically with regard to the release of retention
5 pursuant to Article 6, specifically ¶ 6.02, of the Contract.

6 29. Defendant SL has acted in bad faith by refusing to pay Plaintiff IWS for the
7 retention amount, despite issuing a Certificate of Substantial Completion for the Project
8 and allowing the required amount of time to pass.

9 30. Defendant SL has refused to pay IWS even after their research into the
10 pump motor failures for Well No. 11 and 12 concluded that the failure of the pump
11 motors was due to improper engineering and design of the pump motor controls. More
12 specifically, the omission of sine wave filters that were required due to the more than
13 allowable length of the motor conductors between the Variable Frequency Drives
14 (“VFD”) that are controlling the motors and the motors themselves.

15 31. In addition, the motor that was taken from Well No. 11 in October 2018
16 was replaced under warranty.

17 32. Further, the City Council approved additional expenditures relating to a
18 capacitor bank and other equipment all relating to the design and not the construction
19 performed by IWS.

20 33. IWS did not design the system but was the contractor that performed their
21 work in a timely and workmanlike manner and has still not been paid the retention for the
22 work that was identified as substantially complete on November 3, 2015.

34. Defendant SL refused to even respond to the Exhibit A Notice of Claim.

35. Defendant SL's issues with regard to their fully operational system has nothing to do with the performance of the contract by IWS.

36. To continue to refuse to pay the retention when Defendant SL's own expert identified the design issues, is a breach of the Covenant of Good Faith and Fair Dealing.

37. Plaintiff's Electrical Engineer, Richard J. Moss, reviewed the City's reports, which identifies the key fact that SL acknowledges the design issue. A copy of Mr. Moss' report is attached hereto as Exhibit F and incorporated herein by reference.

38. Defendant SL has failed to act in good faith, that failure being a material breach of the contract and the above covenant.

39. The actions of Defendant SL have caused damages to IWS.

WHEREFORE, Plaintiff IWS respectfully requests that this Court enter judgment against Defendant SL on its Third count of its Complaint as follows:

- A. For financial damages in an amount to be determined at trial;
- B. For compensatory and consequential damages in an amount to be proven at trial;
- C. Costs and reasonable attorneys' fees pursuant to the Contract and A.R.S. §12-341.01;
- D. For interest at 1% per month, pursuant to A.R.S. §34-221(J);
- E. For such other and further relief as the Court deems just and proper.

COUNT IV
(Violation of Arizona's Public Prompt Payment Act, A.R.S. §34-226)

1
2 29. Plaintiff IWS re-alleges and incorporates by reference paragraphs the
3 allegations contained in paragraphs 1 through 28 of its Complaint, as if fully set forth
4 herein.
5

6 30. Plaintiff IWS had a direct contract with Defendant SL to provide labor and
7 materials to the project.
8

9 31. Pursuant to A.R.S. §34-226, Defendant SL was required to make prompt
10 payments of all progress and final payment application within the time period set forth in
11 the Act.
12

13 32. Plaintiff IWS never received any written statements disputing its final
14 billing related to the workmanship performed by IWS.
15

16 33. Defendant SL has no legal or contractual basis to withhold payment from
17 Plaintiff IWS.
18

19 34. As a result of Defendant SL's violation of Arizona's Public Prompt
20 Payment Act, Plaintiff IWS is entitled to pre- and post-judgment interest at the rate of 1
21 % per month from November 3, 2017.
22

23 35. Pursuant to A.R.S. §34-226, Plaintiff is also entitled to attorneys' fees and
24 costs.
25

26 **WHEREFORE**, IWS respectfully requests that this Court enter judgment against
27 Defendant SL for its fourth count of its Complaint as follows:
28

A. Granting judgment for the principal amount of \$100,891.27, plus
applicable pre and post judgment interest at the highest legal rate

1 until paid in full.

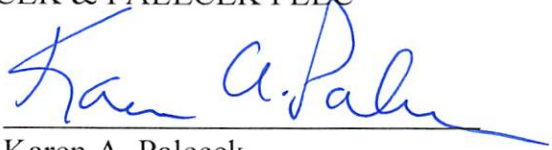
2 B. Costs and reasonable attorneys' fees;

3 C. For interest at 1% per month pursuant to A.R.S. §34-221(J);

4 D. For such other and further relief as the Court deems just and proper.

5
6
7 **RESPECTFULLY SUBMITTED** this 2nd day of May, 2019.

8
9 PALECEK & PALECEK PLLC

10
11 By: 

12 Karen A. Palecek
13 6263 N. Scottsdale Rd., #144
14 Scottsdale, Arizona 85250
15 Attorneys for Plaintiff



GUST ROSENFELD P.L.C.
One S. Church Avenue, Suite 1900
Tucson, Arizona 85701-1627
Tel: (520) 628-7070
Fax: (520) 624-3839
Michael S. Woodlock - 019373
woodlock@gustlaw.com

Attorneys for City of San Luis

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA
IN AND FOR THE COUNTY OF YUMA

INTEGRATED WATER SERVICES, INC., a
Colorado corporation,

Plaintiff,

v.

CITY OF SAN LUIS, a political subdivision
of the State of Arizona; JOHN DOES 1-100;
JANE DOES 1-100, BLACK
CORPORATIONS 1-100, and WHITE
PARTNERSHIPS 1-100,

Defendants.

CASE NO. S1400CV201900321

DEFENDANT'S ANSWER

- AND -

COUNTER-CLAIM

(Assigned to the Honorable
Larry Kenworthy)

Defendant City of San Luis (hereinafter "Defendant") answers Plaintiff's
Complaint as follows:

Defendant denies each and every allegation that is not specifically admitted to
herein.

GENERAL ALLEGATIONS

1. Upon information and belief, Defendant admits the allegations contained
in Paragraph 1 of the Complaint.

2. Upon information and belief, Defendant admits the allegations contained
in Paragraph 2 of the Complaint.

1 3. Defendant admits the allegations contained in Paragraph 3 of the
2 Complaint.

3 4. Defendant admits that IWS sent a Notice of Claim to the City of San Luis
4 via electronic mail and U.S. Mail on December 7, 2018, but denies any remaining
5 allegations in Paragraph 4 of the Complaint.

6 5. Defendant denies the allegations contained in Paragraph 5 of the
7 Complaint.

8 6. Defendant admits the Court has jurisdiction over the Defendant, but
9 denies any remaining allegations contained in Paragraph 6 of the Complaint.

10 7. Defendant admits the allegations contained in Paragraph 7 of the
11 Complaint.

12 **COUNT 1**

13 **(Breach of Contract)**

14 8. Defendant incorporates by reference the allegations contained in
15 Paragraphs 1 through 7, above, as though fully set forth at this point.

16 9. Defendant admits the allegations contained in Paragraph 9 of the
17 Complaint, but denies that Exhibit B to the Complaint represents the entire Contract.

18 10. Defendant denies the allegations contained in Paragraph 10 of the
19 Complaint.

20 11. Defendant admits the allegations contained in Paragraph 11 of the
21 Complaint.

22 12. Defendant admits the allegations contained in Paragraph 12 of the
23 Complaint.

24 13. Defendant admits the allegations contained in Paragraph 13 of the
25 Complaint.

26 14. Defendant admits that it continues to refuse to pay Plaintiff the retention
27 amount, but denies any remaining allegations in Paragraph 14 of the Complaint.

1 Defendant affirmatively alleges that Plaintiff has never achieved Final Completion of
2 the Project, as defined in the Contract, and as a result the retainage is not due.

3 15. Defendant denies the allegations contained in Paragraph 15 of the
4 Complaint.

5 16. Defendant denies that it is in breach of the Contract, and denies that the
6 Plaintiff has been damaged in the amount of \$100,891.27, or any other amount.

7 17. Defendant admits that the Contract provides for recovery of reasonable
8 costs and reasonable attorney's fees incurred by the prevailing party, but denies any
9 remaining allegations in Paragraph 17 of the Complaint.

10 18. Defendant denies the allegations contained in Paragraph 18 of the
11 Complaint.

12 19. Defendant is unable to either admit or deny the allegations in Paragraph
13 19 of the Complaint.

14 **COUNT II**

15 **(Unjust Enrichment)**

16 20. Defendant incorporates by reference the allegations contained in
17 Paragraphs 1 through 19, above, as though fully set forth at this point.

18 21. Defendant admits that Plaintiff furnished labor, equipment and other
19 services to Defendant, some of which has not been paid, but denies any remaining
20 allegations in Paragraph 21 of the Complaint.

21 22. Defendant admits that Plaintiff performed some work, but denies any
22 remaining allegations in Paragraph 22 of the Complaint.

23 23. Defendant lacks sufficient information to form a belief as to the truth of
24 the allegations contained in Paragraph 23, and therefore denies same. Defendant
25 affirmatively alleges that Plaintiff's right to payment is set forth in and to be determined
26 in accordance with the provisions contained in the parties' Contract.
27

24. Defendant denies the allegations contained in Paragraph 24 of the Complaint.

25. Defendant denies the allegations contained in Paragraph 25 of the Complaint.

COUNT III

(Breach of Covenant of Good Faith and Fair Dealing)

26. Defendant incorporates by reference the allegations contained in Paragraphs 1 through 25, above, as though fully set forth at this point.

27. Defendant admits the allegations contained in Paragraph 27 of the Complaint.

28. Defendant admits that it was required to comply with the terms of the parties' Contract, and affirmatively alleges that it has done so. Defendant denies that the release of retainage is governed by ¶ 6.02 of the Contract.

29. Defendant denies the allegations contained in Paragraph 29 of the Complaint.

30. Defendant admits that its investigation into the cause of pump motor failures revealed, among other things, improper engineering and design of the pump motor controls, including omission of sine wave filters. Defendant affirmatively alleges that: (a) section 1.5(A) of the Specifications to the Contract contains a warranty from IWS that the mechanical equipment and electrical equipment installed would be “fit and sufficient for the purposes intended” and a warranty against manufacturing and/or design inadequacies; and (b) its investigation into the cause of pump motor failures also revealed workmanship issues including improper splices and missing ground conductors.

31. Defendant admits that the motor taken from Well No. 11 in October 2018 was replaced under warranty; however, the manufacturer provided only the motor, not the labor and other materials required to re-install the motor.

32. Defendant admits the allegations contained in Paragraph 32 of the Complaint.

33. Defendant admits that Plaintiff did not design the system, and has not been paid the remaining retention amount, and admits that the work was identified as substantially complete on November 3, 2015. Defendant denies the remaining allegations contained in Paragraph 33 of the Complaint. Defendant affirmatively alleges that Plaintiff gave a warranty against design inadequacies, and warranted that the electrical equipment it installed would be fit and sufficient for the Project.

34. Defendant admits that it did not respond to the Notice of Claim, but denies the remaining allegation in Paragraph 34 of the Complaint.

35. Defendant denies the allegations contained in Paragraph 35 of the Complaint, and affirmatively alleges that the system is not and never has been fully operational.

36. Defendant denies the allegations contained in Paragraph 36 of the Complaint.

37. Defendant admits that its consultant has identified design issues, and denies the remaining allegations in Paragraph 37 of the Complaint. Defendant affirmatively alleges that Plaintiff gave a warranty against design inadequacies, and warranted that the electrical equipment it installed would be fit and sufficient for the Project.

38. Defendant denies the allegations contained in Paragraph 38 of the Complaint.

39. Defendant denies the allegations contained in Paragraph 39 of the Complaint.

COUNT IV

(Violation of Arizona's Public Prompt Payment Act, A.R.S. §34-226)

40. Defendant incorporates by reference the allegations contained in Paragraphs 1 through 39, above, as though fully set forth at this point.

41. Defendant admits the allegations contained in the second Paragraph 30 of the Complaint.

42. Defendant admits that it was required to make payments in accordance with the provisions of the Prompt Pay Act, and denies the remaining allegations contained in the second Paragraph 31 of the Complaint.

43. Defendant denies the allegations contained in the second Paragraph 32 of the Complaint.

44. Defendant denies the allegations contained in the second Paragraph 33 of the Complaint.

45. Defendant denies the allegations contained in the second Paragraph 34 of the Complaint.

46. Defendant denies the allegations contained in the second Paragraph 35 of the Complaint.

AFFIRMATIVE DEFENSES

47. As and for its affirmative defenses, Defendant CITY OF SAN LUIS alleges: material breach by Plaintiff; waiver; estoppel; ratification; accord and satisfaction; payment; release; lack of substantial performance by Plaintiff; failure of consideration; statutory and/or contractual limitations on liability; failure to mitigate damages; negligence of others not named as parties; failure to name indispensable parties; statute of limitations; failure to state a claim upon which relief can be granted; any and all affirmative defenses contained in Arizona Rules of Civil Procedure, Rule 8 and/or Rule 12; and any other matter constituting an avoidance or affirmative defense that may become known to the Defendant during the course of disclosure and discovery.

WHEREFORE, having fully answered the Complaint, Defendant CITY OF SAN LUIS prays that Judgment be entered as follows:

1 for the Project.

2 6) IWS expressly and impliedly warranted that the Work would be
3 completed in accordance with the requirements of the Contract Documents, that the
4 materials and equipment furnished thereunder would be of good quality, and that the
5 Work would be free from defects.

6 7) IWS expressly warranted that the mechanical equipment and electrical
7 equipment installed on the Project would be “fit and sufficient for the purposes
8 intended” and gave an express warranty against manufacturing and/or design
9 inadequacies.

10 8) The intent of the Contract was for the City to have a “turn-key” system
11 that “will be a complete and fully functioning filtration system.”

12 9) IWS was required under the Contract to achieve substantial completion of
13 the Project within 270 days of the Contract Start Time, and achieve final completion
14 within 300 days of the Contract Start Time. Pursuant to the Contract documents, final
15 acceptance of all material, equipment and work would not occur until it was determined
16 by the City “that there has been full and complete performance of the contract without
17 claim of deficiency or breach.”

18 10) The Contract required that IWS promptly correct or replace defective
19 Work and pay all costs, losses, and damages, including costs of engineering services,
20 attorneys' fees, and court costs, arising out of the correction of defective Work.

21 11) IWS performed the substantial portions of the original installation of the
22 Project between January 2015 and November 2015. Within a few months, the City
23 began experiencing failures in the pump motors and motor controls, which problems
24 have never been fully resolved. Consequently, the City has never had a complete and
25 fully functioning filtration system, and has never determined that there has been full and
26 complete performance of the Contract without claim of deficiency or breach.

27 12) The City gave written notice to IWS of deficiencies in the design,

1 equipment, installation and performance of the Project on or before August 15, 2016.

2 13) The Contract provides that after Substantial Completion, IWS shall pay
3 the City liquidated damages in the sum of \$1,000 for each day after the time allowed for
4 final completion, until the Work is completed and ready for final payment.

5 14) Despite demands by the City, IWS has failed and refused to take
6 appropriate steps to correct the failures and deficiencies in the Project and systems, such
7 that the City has had to undertake its own efforts to make the Project a complete and
8 fully functioning filtration system.

9 **COUNT ONE**

10 **(Breach of Contract)**

11 15) The City incorporates by reference the allegations contained in Paragraphs
12 1 through 14, above, as though fully set forth at this point.

13 16) The City timely performed all of its obligations under the Contract
14 documents. IWS did not perform its obligations under the Contract, in that it failed to
15 perform the Work in a manner that met the specifications and warranties set forth in the
16 Contract documents and otherwise failed to perform its functions as expressly and
17 impliedly warranted .

18 17) The City has been damaged by IWS's breach of the Contract in an amount
19 in excess of \$150,000, including but not limited to additional engineering costs, staff
20 costs, equipment costs, and other costs allowed under the Contract documents in the
21 event of defective Work by IWS.

22 18) The City has been further damaged by IWS's breach of the Contract in the
23 amount of the liquidated damages required in the Contract from the date specified for
24 final payment (30 days after Substantial Completion) until such time as it is determined
25 that the City has a turn-key, fully functional and operational filtration system.

26 19) This dispute arises from contract, such that the City is entitled to recover
27 its attorneys' fees pursuant to the terms of the Contract and/or A.R.S. § 12-341.01.

1 **COUNT TWO**

2 **(Breach of the Covenant of Good Faith and Fair Dealing)**

3 20) The City incorporates by reference the allegations contained in Paragraphs
4 1 through 19, above, as though fully set forth at this point.

5 21) The Contract includes an implied covenant of good faith and fair dealing.

6 22) By its actions as alleged above, including without limitation the
7 allegations in Paragraph 12, IWS breached the covenant of good faith and fair dealing
8 by denying the City the of, and preventing the City from enjoying, the benefits due the
9 City under the Contract.

10 23) As a natural and foreseeable consequence of IWS's breach of the covenant
11 of good faith and fair dealing, the City has been damaged in an amount to be established
12 by proof at the time of trial.

13 WHEREFORE, Counterclaimant CITY OF SAN LUIS prays for judgment as
14 follows:

- 15 A. For compensatory damages in an amount to be determined at trial,
16 according to proof;
17 B. For costs incurred in the defense of this action;
18 C. For attorneys' fees incurred in the defense of this action; and
19 D. For such other and further relief as the Court deems just and
20 proper.

21 DATED this 13th day of June 2019.

22 **GUST ROSENFELD P.L.C.**

23
24 By: /s/ Michael Woodlock
25 Michael Woodlock
26 Attorneys for Defendant City of San
27 Luis

1 ORIGINAL E-filed via Turbocourt and
2 COPY E-served this 13th
day of June, 2019, to:

3 Karen A. Palecek
4 PALECEK & PALECEK PLLC
5 6263 N. Scottsdale Road, #144
6 Scottsdale, AZ 85250
Phoenix, Arizona 85016
Attorneys for Plaintiff

7 By Jackie Clark

MINUTES
Regular Council Meeting
San Luis City Council
San Luis Council Chambers
1090 E. Union Street
August 22, 2018
7:00 p.m.

APPROVED by the City Council Date: September 26, 2018 Clerk's Office: /s/ S. Cornelio

1. CALL TO ORDER/ROLL CALL: Mayor Gerardo Sanchez called the Regular City Council meeting to order at approximately 7:04 p.m.

PRESENT: Mayor Gerardo Sanchez
Council Member Mario Buchanan Jr.
Council Member Africa Luna-Carrasco
Council Member Matias Rosales
Council Member Gloria Torres
Council Member Ruben Walshe

ABSENT: Vice Mayor Maria Cecilia Ramos

OTHERS PRESENT: Sonia Cornelio, City Clerk
Angel Ramirez, Assistant Fire Chief
Eulogio Vera, Director of Public Works
Isaac Gutierrez, GIS Technician
Jesus Meza, Assistant Director of Parks and Recreation
Jonathan Dumadag, I.T. Technician
Jorge Perez, Billing & Collections Manager
Kay Macuil, City Attorney
Manuel Rojas, Assistant Director to Public Works
Monica Castro, Director of Finance
Olivia Jenkins, Human Resources Manager
Ralph Velez, City Consultant
Richard Jessup, Acting Chief of Police
Rogelio Martinez, Economic Development
Adrian Siqueiros, Resident
Caty Navarro, Reporter
Javier Vargas, Resident
Jose Luis Reyes Jr., Resident
Lucy Lopez, Reporter

2. PLEDGE OF ALLEGIANCE

The Pledge of Allegiance was led by Mayor Gerardo Sanchez.

3. INVOCATION

The Invocation was led by Richard Jessup, Acting Chief of Police.

4. PRESENTATION/PROCLAMATION

4. A. Presentation by Ms. Shara Merten, President and Chief Executive Officer, Yuma Community Food Bank. (Ms. Shara Merten, President and Chief Executive Officer)

Ms. Shara Merten, President and Chief Executive Officer for Yuma Community Food Bank, presented Yuma Community Food Bank's impact for Fiscal Year 2018 to the community of San Luis. Ms. Merten proceeded with an overview which included the different programs, service and future growth in the City of San Luis.

Mayor Gerardo Sanchez added that every year the Yuma Community Food Bank continues to improve their service in terms of the quantity of food and is happy to support Yuma Community Food Bank and grateful for what they do for the City of San Luis. Ms. Merten mentioned that the City of San Luis is the only municipality that support Yuma Community Food Bank and thanked the Mayor and City Council for their continued support.

4. B. PROCLAMATION

- September 2018 Card Sign-Up Month

Mrs. Sonia Cornelio, City Clerk, read the proclamation in its entirety.

There was nobody present from the Library; Mayor Gerardo Sanchez stated the library card is a very important document specially for the kids.

5. CONSENT AGENDA

5. A. MINUTES OF

- Regular Council meeting held July 25, 2018
- Work Session scheduled August 1, 2018
- Regular Council meeting held August 8, 2018

5. B. DISBURSEMENTS FROM JULY 28, 2018 THROUGH AUGUST 10, 2018

Total Disbursements \$1,094,536.14

(One Million, Ninety-Four Thousand, Five Hundred Thirty-Six Dollars and Fourteen Cents)

MOTION: Council Member Gloria Torres/Council Member Ruben Walshe to approve the Consent Agenda as presented. Motion passed unanimously.

6. DISCUSSION AND POSSIBLE ACTION ITEMS:

6. A. Discussion and possible directions to staff and presentation by Ron Pickett updating San Luis on the Solar Wind Energy Tower project. (Kay Marion Macuil, City Attorney)

Mr. Ron Pickett, stated that he is pleased to bring the City Council up to date on this project. He proceeded by adding that one of the difficulties on a project like this is that you cannot do everything in parallel and there have been some challenges. Mr. Pickett explained the tower is so tall in San Luis is because when the temperature reaches above 90 degrees and the relative humidity is below 20%, they produce 70% of the energy that is going to be produced during the year from this so they have to target out of this efficiency so all this was reverse engineering. Last year this problem was resolved and they were going to decide how long and wide the tunnel was going to be to effectively take the downdraft winds, push the winds into the tower and the velocity of those winds determines how much energy can be created. Mr. Pickett explained that they did a four (4) month exercise and scenarios to determine if the height of the tower could be lowered as well as reductions in costs, overall the project is well underway.

Mayor Gerardo Sanchez commented that last time Mr. Pickett was before the City Council he discussed the need to guarantee those days that the power was not being generated and the addition of a gas-burning power plant next to it. Now that the studies indicate that the tower does not need be as tall and be more efficient, he asked what will happen to the gas burning power station and the creation of jobs.

Mr. Pickett responded that at this particular time he doesn't think it will be necessary as when they finish with the extractions of the third turbine, the lowest output is nearly 100 megawatts and the gas fire with the combined sycoplan was to give 125 megawatts of guarantee. Therefore, unfortunately if this goes from 30 generator stations to 20, there was a staffing requirement for each generator station, that will be reduced.

Mayor Gerardo Sanchez mentioned that San Luis Rio Colorado, Sonora is interested in something like this and asked if Mr. Pickett will be working with them also.

Mr. Pickett answered that they have had some discussions with San Luis Rio Colorado, Sonora as they have a real power problem with the city. He thanked the Mayor and City Council for their support.

No action was required on this item by the Mayor and City Council.

6. B. Discussion and possible action on any and all matters regarding the appointment of members to serve on the San Luis Complete Count Committee for the Census 2020. (Jose A. Guzman, Director of Planning and Zoning)

Mr. Isaac Gutierrez, GIS Department, explained that on August 8, the City Council adopted Resolution No. 2052 to appoint the Complete Count for the Census. He added that San Luis will be represented by two (2) city staff members, two (2) community leaders, and two (2) Council Members. City Council needs to appoint members to this committee. The department does have a few recommendations, staff recommends the appointment of two (2) city staff members Jose A. Guzman and Isaac Gutierrez; two (2) Council Members; two (2) Community Leaders Tadeo De La Hoya and another one of Mayor and City Council's choice.

Mayor Gerardo Sanchez, Council Members Africa Luna-Carrasco and Matias Rosales stated that this is very important. Council Member Africa Luna-Carrasco stated that she has some names in mind but want to ask first before appointing him/her. Mayor Gerardo Sanchez said that five (5) members can be appointed except the sixth (6th) one which can be appointed at the next Regular City Council meeting.

MOTION: Council Member Africa Luna-Carrasco/Council Member Mario Buchanan Jr. to appoint City Staff Member Jose A. Guzman to the Complete the Count Committee, to appoint City Staff Member Isaac Gutierrez to the Complete the Count Committee, to appoint Vice Mayor Maria Cecilia Ramos to the Complete the Count Committee, to appoint Council Member Matias Rosales to the Complete the Count Committee and to appoint Community Leader Tadeo A. De La Hoya to the Complete the Count Committee. Motion passed unanimously.

MOTION: Mayor Gerardo Sanchez/Council Member Ruben Walshe to continue appointment of a Community Leader to the Complete the Count Committee to the next Regular City Council meeting. Motion passed unanimously.

6. C. Public hearing followed by discussion and possible action on any and all matters regarding recommendation of a Special Event Liquor License application to the Arizona Department of Liquor Licenses and Control to authorize the City of San Luis Parks and Recreation Department to sell alcohol during the Exhibition Baseball Game event to be held on September 27, 2018. (Lizandro Galaviz, Director of Parks and Recreation)

A. Open public hearing

MOTION: Council Member Mario Buchanan Jr./Council Member Africa Luna-Carrasco to open public hearing. Motion passed unanimously.

1. Presentation by staff and/or applicant

Mr. Jesus Meza, Assistant Director of Parks & Recreation, provided a brief summary of the event to take place at the Exhibition Baseball Game to be held on September 27, 2018. Staff requested authorization to apply for the alcohol permit to be issued by the Arizona Department of Liquor Licenses and Control.

2. Call to the public on this item

There were no comments from the public on this item.

B. Close public hearing

MOTION: Council Member Mario Buchanan Jr./Council Member Ruben Walshe to close public hearing. Motion passed unanimously.

C. Action on Special Event Liquor Application to the Arizona Department of Liquor Licenses & Control

MOTION: Council Member Mario Buchanan Jr./Council Member Gloria Torres to recommend approval to the Arizona Department of Liquor Licenses and Control a Special Event Liquor License for the City of San Luis through its Parks & Recreation Department as presented. Motion passed unanimously.

6. D. Discussion and possible action on any and all matters regarding Resolution No. 2053. A resolution of the Mayor and City Council of the City of San Luis, Arizona authorizing and directing the entering into an intergovernmental agreement with the Gadsden Elementary School District # 32 for the construction and maintenance of a retention basin at Ed Pastor Elementary School. (Kay Marion Macuil, City Attorney and Eulogio Vera, Director of Public Works)

Ms. Kay Marion Macuil, City Attorney, explained that this is for Union Street and 6th Street intersection, the agreement for the school to take the runoff water for all of 6th Street, they are legally only to take half and they have agreed to take all of it. They have also agreed to mow the retention basin six (6) months of the year and the city will mow the other six (6) months of the year.

Mr. Eulogio Vera, Director of Public Works, explained that as part of the Union Street improvements project, the city was able to drain Union Street onto the retention basin inside the subdivision, but due to the elevation difference on 6th Avenue the city cannot get that runoff onto that retention basin, therefore the natural grades take the water into the school. This intergovernmental agreement (IGA) was negotiated which includes fencing around the retention basin and maintenance. There is a drainage easement that they will be providing allowing the city to do it. The School Board approved the IGA on Thursday, August 16, 2018.

MOTION: Council Member Gloria Torres/Council Member Ruben Walshe to approve Resolution No. 2053. Motion passed unanimously.

7. CALL TO THE PUBLIC

There were no comments from the public.

8. SUMMARY OF CURRENT EVENTS

Mayor Gerardo Sanchez reminded everyone about the city's election and encouraged voters to cast their vote.

Council Member Matias Rosales reported that after 15 plus years the meadow craft building will be occupied by a tenant and hopefully bring in more tenants and jobs. He also reported that Galeria Café will be moving into the library beginning next month.

Mayor Gerardo Sanchez reported that he and Council Member Matias Rosales met with a company that makes good salsas that want to move in to the City of San Luis and generate approximately 40-50 jobs. Furthermore, he added that the community needs more parks and the city needs to work on this. He also reminded everyone that if a person purchases a used car in the City of San Luis, he/she will be paying 1.5% sales tax, the lowest in the county.

Council Member Africa Luna-Carrasco thanked staff for the recycling project.

9. EXECUTIVE SESSION

Vote to hold an Executive Session pursuant to A.R.S. §§38-431.03(A)(3) and 38-431.03(A)(4)

Discussion and possible action to hold an Executive Session pursuant to A.R.S. §38-431.03(A)(3) and A.R.S. §38-431.03(A)(4) on any and all matters regarding contracts for the manganese filtration project at Well Site 7 for the purpose of discussion or consultation for legal advice or in order to consider the city's position and instruct its attorneys regarding these contracts that are the subject of negotiations, in pending or contemplated litigation or in settlement in order to avoid or resolve litigation. (Kay Marion Macuil, City Attorney)

MOTION: Council Member Mario Buchanan Jr./Council Member Gloria Torres to go into Executive Session at approximately 8:01 p.m. Motion passed unanimously.

10. MOTION TO GO BACK INTO REGULAR SESSION

MOTION: Council Member Matias Rosales/Council Member Mario Buchanan Jr. to go into Regular Session at approximately 8:41 p.m. Motion passed unanimously.

11. DISCUSSION AND POSSIBLE ACTION ITEMS:

11. A. Discussion and possible action on any and all matters regarding the retainage on the Manganese Filtration Project for Well Site 7. (Kay Marion Macuil, City Attorney and Eulogio Vera, Director of Public Works)

Ms. Kay Macuil, City Attorney, said that staff recommends to reject releasing the ½ of the retainage to IWS, they are the contractor.

MOTION: Council Member Matias Rosales/Council Member Mario Buchanan Jr. to reject releasing any of the retainage. Motion passed unanimously.

11. B. Discussion and possible action on any and all matters regarding legal services for Well Site #7 issues on the manganese filtration system. (Kay Marion Macuil, City Attorney and Eulogio Vera, Director of Public Works)

MOTION: Council Member Gloria Torres/Council Member Mario Buchanan Jr. to approve \$30,000.00 for legal services on the manganese filtration system at well site 7. Motion passed unanimously.

12. ADJOURNMENT

MOTION: Council Member Mario Buchanan Jr./Council Member Gloria Torres to adjourn the Regular Council meeting at approximately 8:42 p.m. Motion passed unanimously.



Certification of Council Minutes

I hereby certify that the foregoing minutes are a true and correct copy of the minutes of the Regular Meeting of the San Luis City Council held on August 22, 2018. I further certify the meeting was duly called and held and that the quorum was present and that the City Council approved these minutes at their Regular Meeting held on August 22, 2018.

Dated this 2nd day of October 2018.

/s/ Sonia Cornelio, City Clerk